

3  
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, AND 3 TO THE FUNERAL DIRECTOR.  
PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. RETAIN PAGE 5 FOR OUR FILES.  
PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS  
AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 3			
1. FOR STATE REGISTRAR			2a. DATE KNOWN <input checked="" type="checkbox"/> MONTH DAY YEAR OF ESTI- MATED <input type="checkbox"/> Nov. 20 1983									21. HOUR 11:35 A.M.			
I. DECEASED NAME (TYPE OR PRINT)			FIRST DORIS			MIDDLE J			LAST ALGER						
3. SEX FEMALE		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 6 24 1938			6. AGE (IN YEARS LAST BIRTHDAY) 45 YRS.		7. IF UNDER 1 YR. MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN		2c. DATE PRONOUNCED DEAD Nov. 20 1983		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Texas		7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH WASHINGTON			10. DATE MONTH DAY YEAR 11:35 A.M.					
10. CITY OR TOWN OF DEATH Hagerstown, Md.			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital						12a. USUAL OCCUPATION (TYPE OF WORK) FOR MOST OF WORKING LIFE Housewife			12b. KIND OF BUSINESS OR INDUSTRY MD.			
13a. STATE W.Va.			13b. COUNTY Jefferson		13c. CITY OR TOWN Kearneysville			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Fox Glen Subdivision 99999					
14. FATHER'S NAME FIRST Joe			MIDDLE			LAST Tucker			15. MOTHER'S MAIDEN NAME FIRST Ann			16. ADDRESS P. O. Box 151 Kearneysville, W.Va.			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no			16b. SOCIAL SECURITY NO. 565 46 1624			17. INFORMANT Harry G. Alger			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 8842 Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. } DUE TO, OR AS A CONSEQUENCE OF (b) (BILATERAL SUBDURAL HEMATOMA) DUE TO, OR AS A CONSEQUENCE OF (c)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 13 DAYS			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (d).															
19a. DATE OF OPERATION 11/8/83			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? CRANIOTOMY									20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 4:30 AM Nov. 8 1983			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2) FELL FROM HOSPITAL BED									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) HOSPITAL			21f. LOCATION STREET CITY OR TOWN CITY HOSPITAL, MARTINSBURG, BERKELEY, W. VA.									
22a. I certify that I took charge of the remains described above, held an death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>Edward W. Ditto</i>												TITLE (SPECIFY) M.D. DEPUTY MEDICAL EXAMINER 217 WEST WASHINGTON STREET			
EXAMINER'S NAME (TYPE OR PRINT) EDWARD W. DITTO, III, M.D.												DATE SIGNED Nov. 21, 1983			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 11/23/83			23c. NAME OF CEMETERY OR CREMATORIAL Edge Hill Cemetery			23d. LOCATION CITY OR TOWN Charles Town, Jefferson, W.Va.						
24. FUNERAL DIRECTOR NAME Charles H. Strider, Jr.			ADDRESS Charles Town, W.Va.			25a. DATE REC'D. BY REGISTRAR NOV 28 1983			25b. REGISTRAR'S SIGNATURE <i>John C. Smith</i>						

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												31238					
1. FOR STATE REGISTRAR			REG. NO.														
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
MARY Agnes ARNOLD												NOVEMBER	12	'83	8 25 A.M.		
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 24 HRS					
Female			White			MONTH DAY YEAR May 24 1900			83			MONTHS DAYS					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			IF UNDER 24 HRS					
Maryland			U.S.A.						Washington								
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)									12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Hagerstown			Washington County Hospital									Seamstress			Factory		
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS					
Maryland			Washington			Hagerstown			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			317 South Potomac Street 21740					
14. FATHER'S NAME			FIRST			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME					
			Carlton			P.			Marker			Orpha					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			1714 Howell Road			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
NO			217-28-6327			Mary Mowen			Hagerstown, MD 21740			40 DYS					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)												3 WEEKS					
2050 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												SGS SIS					
DUE TO, OR AS A CONSEQUENCE OF (b) ACUTE MYELOGENOUS LEUKEMIA																	
DUE TO, OR AS A CONSEQUENCE OF (c)																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
CONGESTIVE CARDIAC FAILURE																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED									20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
None												YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from NOVEMBER 8, 1983, to NOVEMBER 12, 1983, that (I/we) last saw the deceased alive on NOVEMBER 11, 1983, and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I/we) (did) (did not) view the body after death.												22b. DATE SIGNED 11-12-83					
22b. SIGNATURE Barry M. Cohen, M.D.			DEGREE M.D.			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>											
22c. PHYSICIAN'S NAME (TYPE OR PRINT) BARRY M. COHEN, M.D.			22d. ADDRESS 339 E. ANTIETAM ST. HAGERSTOWN, MD 21740														
23a. BURIAL, CREMATION, REMOVAL Burial			23b. DATE Nov. 14, 1983			23c. NAME OF CEMETERY OR CREMATORIAL St. Paul's Lutheran			23d. LOCATION CITY OR TOWN Myersville			COUNTY Frederick					
24. FUNERAL DIRECTOR Ricketts Funeral Home												STATE Maryland					
25. DATE REC'D. BY REGISTRAR NOV 17 1983												Signature					



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										31239					
CERTIFICATE OF DEATH										REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR		
Lawrence William Barton Sr.								November 7, 1983					3:55a M		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS					
Male		White		MONTH DAY YEAR January 17, 1906		77		MONTHS DAYS		HOURS MIN.					
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		Washington County MD.							
Maryland		U.S.A.													
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Hagerstown		Washington County Hospital										Laborer		Construction	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS		21740					
Maryland		Washington		Hagerstown		YES <input checked="" type="checkbox"/>		64 1/2 West Franklin Street							
14. FATHER'S NAME		FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME							
		Harry		O.		Barton		Ella Mae Smith							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		18. ADDRESS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
No		213-18-8489		Hazel M. Barton		64 1/2 West Franklin Street Hagerstown, Md. 21740		immediate							
18. CAUSE OF DEATH (Enter only one cause per line for 1a, (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiopulmonary arrest</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>myocardial infarction</i> recent. DUE TO, OR AS A CONSEQUENCE OF (c) <i>ASHD &amp; COPD</i> 7/8.															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
								YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		19									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE					
22a. I certify that (I) (this hospital) attended the deceased from <i>11/7/83</i> to <i>11/7/83</i> , that (I) (we) last saw the deceased alive on <i>11/7/83</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE <i>Michael B. Alyan</i>		DEGREE MD.		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>11/7/83</i>									
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MASSON. B. ALYAN MD		22e. ADDRESS 363 S. Cleveland Ave.													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11-9-83		23c. NAME OF CEMETERY OR CREMATORIAL Cedar Lawn Memorial Pk.		23d. LOCATION CITY OR TOWN Hagerstown, Washington, Md.									
24. FUNERAL DIRECTOR NAME A.K. Coffman Funeral Home, Inc., Hagerstown		ADDRESS		25a. DATE REC'D. BY REGISTRAR NUV 9 1983		25b. REGISTRAR'S SIGNATURE <i>John Coffman</i>									

• The following table gives the

State	Capital	Population	Area	Altitude	Geography	Minerals	Manufactures
Alabama	Montgomery	1,000,000	50,000	1,000	Mountainous	Coal	Iron
Alaska	Juneau	100,000	1,500,000	1,000	Mountainous	Gold	None
Arizona	Phoenix	1,000,000	110,000	1,000	Mountainous	Gold	None
Arkansas	Little Rock	1,000,000	50,000	1,000	Mountainous	Coal	None
California	Sacramento	3,000,000	150,000	1,000	Mountainous	Gold	None
Colorado	Denver	1,000,000	100,000	1,000	Mountainous	Gold	None
Connecticut	Hartford	1,000,000	5,000	1,000	Mountainous	Gold	None
Delaware	Dover	200,000	2,000	1,000	Mountainous	Gold	None
Florida	Tallahassee	1,000,000	100,000	1,000	Mountainous	Gold	None
Georgia	Macon	1,000,000	50,000	1,000	Mountainous	Gold	None
Hawaii	Honolulu	100,000	1,500,000	1,000	Mountainous	Gold	None
Idaho	Boise	1,000,000	100,000	1,000	Mountainous	Gold	None
Illinois	Springfield	3,000,000	150,000	1,000	Mountainous	Gold	None
Indiana	Indianapolis	1,000,000	50,000	1,000	Mountainous	Gold	None
Iowa	Des Moines	1,000,000	50,000	1,000	Mountainous	Gold	None
Kansas	Topeka	1,000,000	50,000	1,000	Mountainous	Gold	None
Louisiana	Baton Rouge	1,000,000	50,000	1,000	Mountainous	Gold	None
Maine	Augusta	200,000	2,000	1,000	Mountainous	Gold	None
Maryland	Annapolis	1,000,000	5,000	1,000	Mountainous	Gold	None
Massachusetts	Boston	1,000,000	5,000	1,000	Mountainous	Gold	None
Michigan	Lansing	1,000,000	50,000	1,000	Mountainous	Gold	None
Minnesota	St. Paul	1,000,000	50,000	1,000	Mountainous	Gold	None
Mississippi	Jackson	1,000,000	50,000	1,000	Mountainous	Gold	None
Missouri	Jefferson City	1,000,000	50,000	1,000	Mountainous	Gold	None
Montana	Helena	1,000,000	100,000	1,000	Mountainous	Gold	None
Nebraska	Lincoln	1,000,000	50,000	1,000	Mountainous	Gold	None
Nevada	Carson City	1,000,000	100,000	1,000	Mountainous	Gold	None
New Hampshire	Concord	200,000	2,000	1,000	Mountainous	Gold	None
New Jersey	Trenton	1,000,000	5,000	1,000	Mountainous	Gold	None
New Mexico	Albuquerque	1,000,000	100,000	1,000	Mountainous	Gold	None
New York	Albany	3,000,000	150,000	1,000	Mountainous	Gold	None
North Carolina	Raleigh	1,000,000	50,000	1,000	Mountainous	Gold	None
North Dakota	Bismarck	1,000,000	50,000	1,000	Mountainous	Gold	None
Ohio	Columbus	1,000,000	50,000	1,000	Mountainous	Gold	None
Oklahoma	Oklahoma City	1,000,000	50,000	1,000	Mountainous	Gold	None
Oregon	Salem	1,000,000	100,000	1,000	Mountainous	Gold	None
Pennsylvania	Harrisburg	1,000,000	5,000	1,000	Mountainous	Gold	None
Rhode Island	Providence	200,000	2,000	1,000	Mountainous	Gold	None
South Carolina	Charleston	1,000,000	50,000	1,000	Mountainous	Gold	None
South Dakota	Sioux City	1,000,000	50,000	1,000	Mountainous	Gold	None
Tennessee	Nashville	1,000,000	50,000	1,000	Mountainous	Gold	None
Texas	Austin	3,000,000	150,000	1,000	Mountainous	Gold	None
Utah	Salt Lake City	1,000,000	100,000	1,000	Mountainous	Gold	None
Vermont	Montpelier	200,000	2,000	1,000	Mountainous	Gold	None
Virginia	Richmond	1,000,000	5,000	1,000	Mountainous	Gold	None
Washington	Olympia	1,000,000	100,000	1,000	Mountainous	Gold	None
West Virginia	Morgantown	1,000,000	5,000	1,000	Mountainous	Gold	None
Wisconsin	Madison	1,000,000	5,000	1,000	Mountainous	Gold	None
Wyoming	Cheyenne	1,000,000	100,000	1,000	Mountainous	Gold	None

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IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner may be notified at this time.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH															
3 3 3 1 2 4 0											REG. NO.				
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR						
Agnes I. Beatty						Nov 21 1883			5:00 PM						
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.			
Female		White		07 08 1895			88			YRS.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.					
Hagerstown		U. S. A.					Washington								
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Hagerstown		Washington County Hospital										Housewife		Own Home	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS			21740			
Maryland		Washington		Hagerstown					1240 Ravenwood Heights						
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST													
Ceits Rufus Foltz		Etta Mae Williams													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS								
No		(IF YES, GIVE WAR OR DATES)		220-16-2087			Mrs. Ethel L. Horn, Hagerstown, Md. 21740								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Renal Failure</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>			
4039 Conditions, if any, which gave rise to the immediate cause (a), stating the underlying cause last. (b) <u>Nephrosclerosis</u>															
DUE TO, OR AS A CONSEQUENCE OF (c)												<u>Years</u>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)										
21d. INJURY OCCURRED AT WHILE WORK <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>19-81</u> to <u>11-21</u> 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>11-23</u> 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death.												22c. DATE SIGNED <u>11-20-83</u>			
22b. SIGNATURE <u>Charles P. Spencer</u>		22c. DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>										
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Charles P. Spencer</u>		22e. ADDRESS <u>1198 Kelly Ave Hagerstown Md.</u>													
23a. BURIAL, CREMATION, REMOVAL IS IT Burial		23b. DATE 11-30-83			23c. NAME OF CEMETERY OR CREMATORIAL Funkstown Cemetery			23d. LOCATION CITY OR TOWN Funkstown, Wash. Co., Md.			COUNTY		STATE		
24. FUNERAL DIRECTOR NAME John H. Bast, Jr.		ADDRESS Boonsboro, Md. 21713			25a. DATE REC'D. BY REGISTRAR DEC 5 1983			25b. REGISTRAR'S SIGNATURE <u>John H. Bast, Jr.</u>							

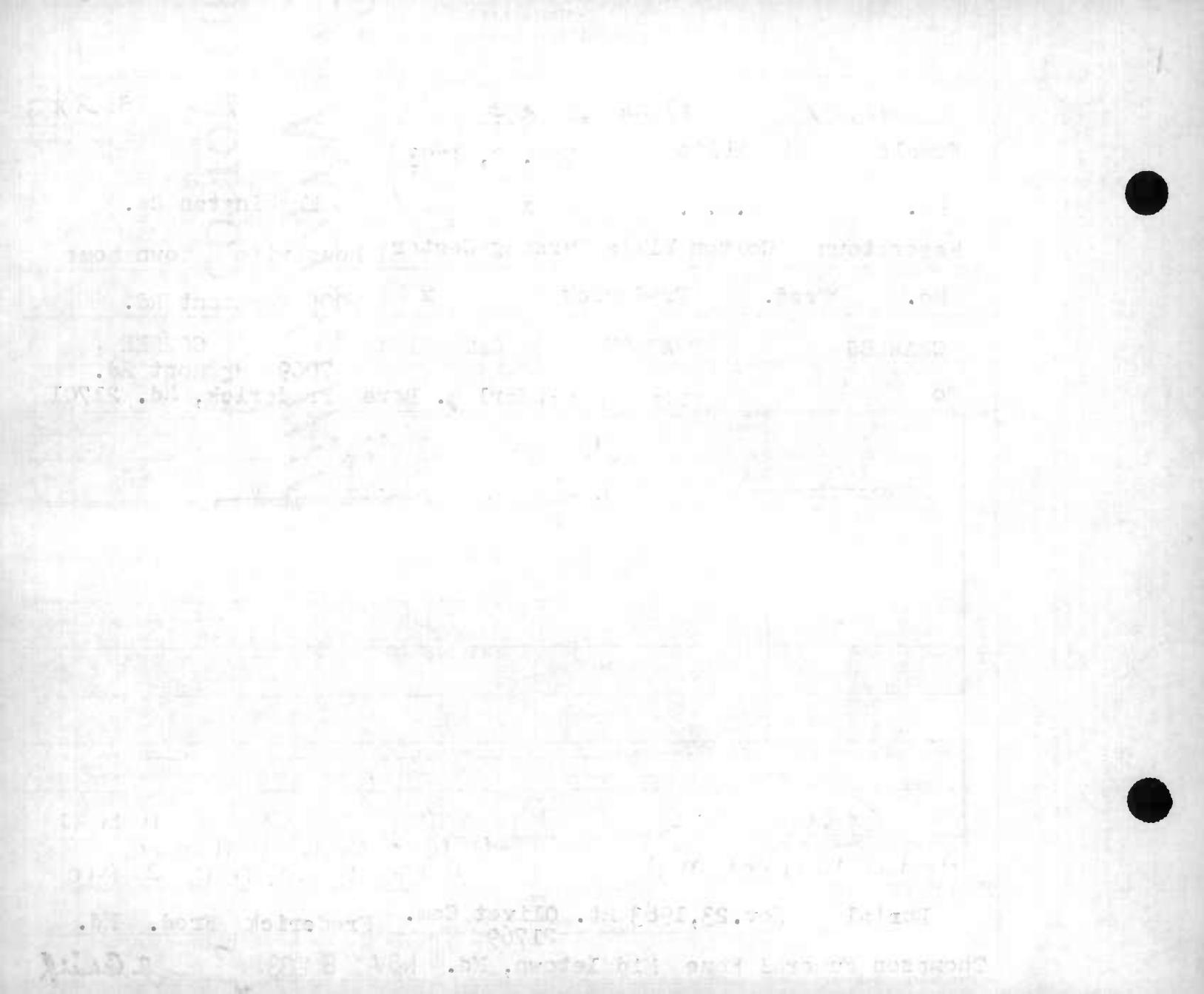


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 and 2 should be detached for use as the burial/transit permit. Then please remove carbon paper. Page 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

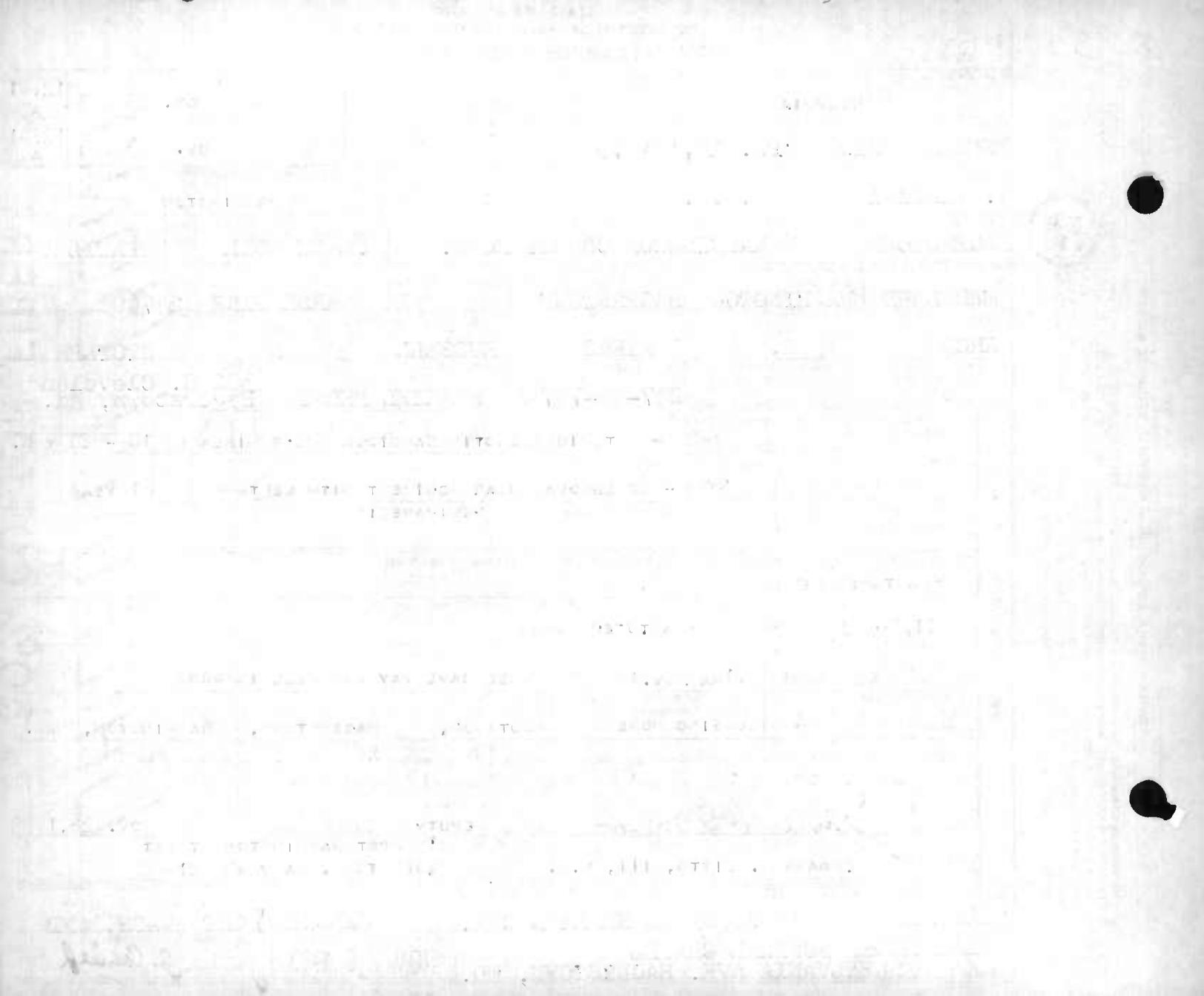
IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, no medical certificate is required.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												3	3	1	2	4	1	
												REG. NO. 31241						
1 - FOR STATE REGISTRAR			2a DATE OF DEATH MONTH DAY YEAR 11 21 83												2b HOUR 22 27 AM			
1. DECEASED NAME (TYPE OR PRINT) ALICE			MIDDLE Helena			LAST Bere			5 DATE OF BIRTH MONTH Dec. DAY 3, 1893			6. AGE (IN YEARS LAST BIRTHDAY) 89			IF UNDER 1 YEAR MONTHS 0		IF UNDER 24 HRS HOURS 27	
3. SEX Female			4. RACE White												YRS			
7a. BIRTHPLACE COUNTRY Md.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Washington Co. MD.						
10. CITY OR TOWN OF DEATH Hagerstown			NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Colton Villa Nursing Center			11a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife			12b. KIND OF BUSINESS OR INDUSTRY own home						
13a. STATE Md.			13b. COUNTY Frederick			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS 7005 Edgemont Rd. 21701									
14. FATHER'S NAME FIRST CHARLES			MIDDLE MIDDLE PEARSON			15. MOTHER'S MAIDEN NAME CATHERINE			16. SOCIAL SECURITY NO. 213-74-8761			17. INFORMANT Earl W. Bere Frederick, Md. 21701			CONNER			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 4149 IMMEDIATE CAUSE (a)			Cardiac arrest												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause if any			DUE TO, OR AS A CONSEQUENCE OF (b) 15 chronic heart disease															
			DUE TO, OR AS A CONSEQUENCE OF (c)															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)												
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE				
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																		
22b. SIGNATURE A.R. S.															22c. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Abdul Waheed, M.D.			22e. ADDRESS 1600 Oak Hill Ave. Hagerstown, MD 21740												22f. DATE SIGNED 11-21-83			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Nov. 23, 1983			23c. NAME OF CEMETERY OR CREMATORIAL Mt. Olivet Cem. 21769			23d. LOCATION CITY OR TOWN Frederick			COUNTY		STATE				
24. FUNERAL DIRECTOR NAME Thompson Funeral Home			ADDRESS Middletown, Md.			25a. DATE REC'D. BY REGISTRAR NOV 28 1983			25b. REGISTRAR'S SIGNATURE J. and C. C. C. C. C.									



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM FM-3 RETAIN COPIES FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE KEPT WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 21201, BALTIMORE, MARYLAND, 21201, PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 31242								
1- FOR STATE REGISTRAR			I. DECEASED NAME FIRST DELPHIA			MIDDLE V			LAST BERRY			2a. DATE KNOWN <input checked="" type="checkbox"/> MONTH NOV. DAY 23 1983 YEAR 83 HOUR 12:41 AM								
3. SEX FEMALE			4. RACE WHITE			5. DATE OF BIRTH MONTH APR. DAY 23, YEAR 04			6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS.			7. IF UNDER 1 YR. MONTHS 0			8. IF UNDER 24 HRS. DAYS 0			9. DATE ESTIMATED <input checked="" type="checkbox"/> MONTH NOV. DAY 23 1983 YEAR 83 HOUR 12:41 AM		
10. BIRTHPLACE W. VIRGINIA			11. CITIZEN OF WHAT COUNTRY? U.S.A.			12. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			13. WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			14. DATE PRONOUNCED DEAD NOV. 23 1983			15. BALTIMORE CITY OR COUNTY OF DEATH WASHINGTON MD.					
16. CITY OR TOWN OF DEATH HAGERSTOWN			17. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION WASHINGTON COUNTY HOSP.			18. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) MARYLAND WASHINGTON HAGERSTOWN			19. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) MARYLAND WASHINGTON HAGERSTOWN			20. USUAL OCCUPATION (TYPE OF WORK) PLANT WORK			21. KIND OF BUSINESS OR INDUSTRY TEXTILES					
22. FATHER'S NAME FIRST ARCH			MIDDLE A.			LAST MYERS			23. MOTHER'S MAIDEN NAME FIRST RUSSELL			MIDDLE M			LAST STOTLER					
24. WAS DECEASED EVER IN U.S. ARMED FORCES? YES NO			25. SOCIAL SECURITY NO. 217-10-7174A			26. INFORMANT MURRIEL BERRY			27. STREET ADDRESS MARSH PIKE 21740			28. ADDRESS 382 S. Cleveland Hagerstown, Md.			29. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 - 20 YRS.					
30. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 429 IMMEDIATE CAUSE (a) #429 - ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause lost. 436 DUE TO, OR AS A CONSEQUENCE OF (b) #436 - CEREBROVASCULAR ACCIDENT WITH LEFT HEMIPARESIS (c)																				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a). FRACTURED FEMUR																				
31. DATE OF OPERATION 11/18/83			32. CONDITION FOR WHICH OPERATION WAS PERFORMED? FRACTURED FEMUR			33. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
34. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH			35. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 8:10 AM Nov. 18 1983			36. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) KNEE GAVE WAY AND FELL IN ROOM														
37. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK			38. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) NURSING HOME			39. LOCATION STREET ROUTE #8, CITY OR TOWN HAGERSTOWN, COUNTY WASHINGTON, STATE MD.														
40. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>Edward W. Ditto, M.D.</i>												41. TITLE (SPECIFY) M.D. DEPUTY MEDICAL EXAMINER 217 WEST WASHINGTON STREET EXAMINER'S NAME (TYPE OR PRINT) EDWARD W. DITTO, III, M.D. ADDRESS HAGERSTOWN, MARYLAND 21740 DATE SIGNED Nov. 23, 1983								
42. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			43. DATE 11/26/83			44. NAME OF CEMETERY OR CEMATORIAL GREENLAWN CEM.			45. LOCATION CITY OR TOWN WILLIAMSPORT COUNTY WASH. STATE MD.											
46. FUNERAL DIRECTOR REST HAVEN FUNERAL CHAPEL 1601 PENNSYLVANIA AVE. HAGERSTOWN, MD.			47. DATE REC'D. BY REGISTRAR NOV 28 1983			48. REGISTRAR'S SIGNATURE <i>John J. Conroy</i>														

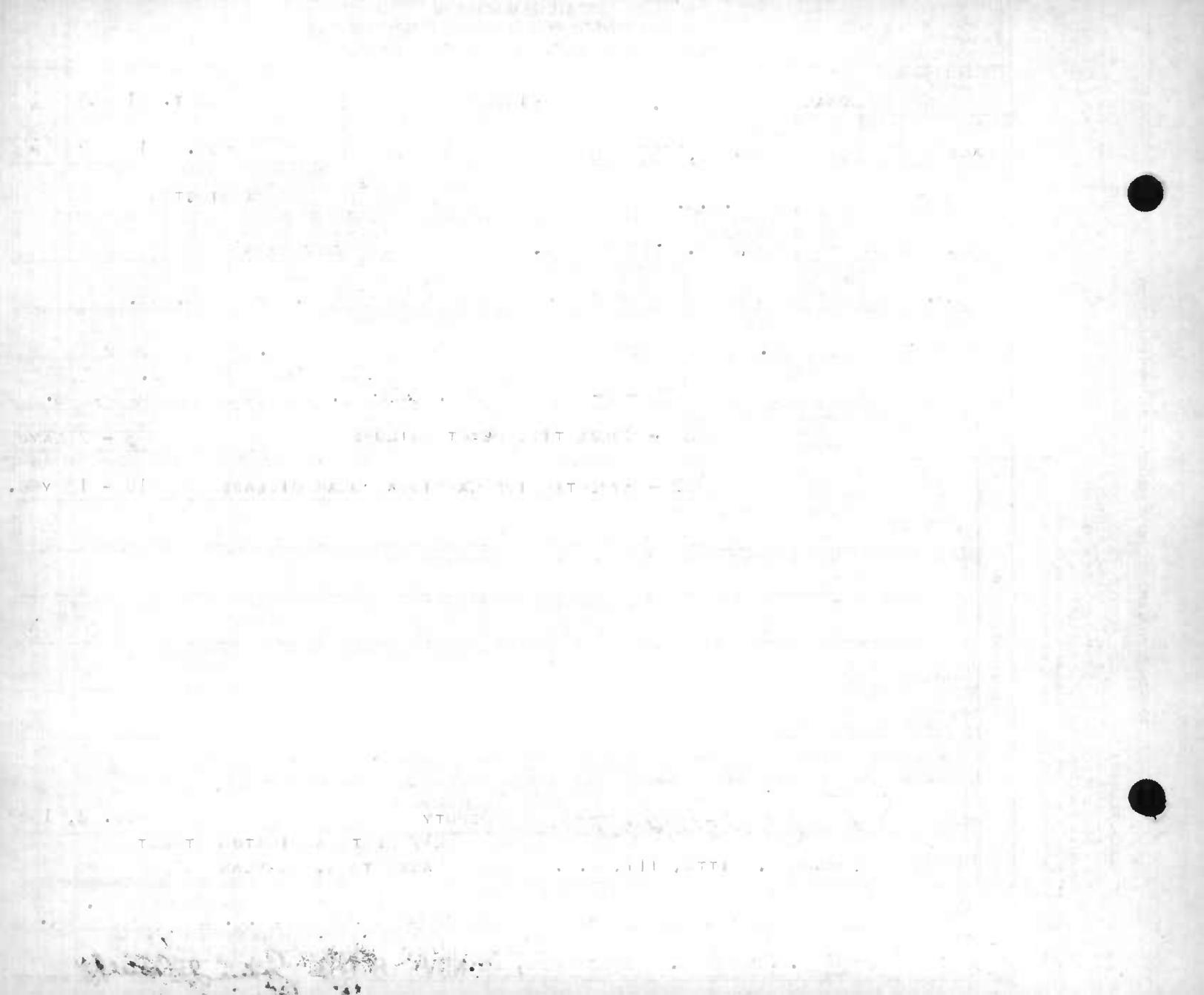


2

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												31243									
												REG. NO.									
1- FOR STATE REGISTRAR		I. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE KNOWN OF ESTI- MATED		MONTH	DAY	YEAR	2b. HOUR 8:00 A.M.		
		DONALD			L.			BIRELY						Oct. 31		1983					
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		MONTH	DAY	YEAR	2d. HOUR 7:00 P.M.		
MALE		White		June 17, 1927			56 yrs.			MONTHS		DAYS		HOURS		MIN		Nov. 1		1983	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED WIDOWED			NEVER MARRIED DIVORCED			9. BALTIMORE CITY OR COUNTY OF DEATH WASHINGTON										
Maryland		U.S.A.									MD.										
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY													
Hagerstown		124 N. Prospect St.						unemployed													
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS											
Md.		Washington		Hagerstown			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			124 N. Prospect St.			21740								
14. FATHER'S NAME		FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME			16. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS							
Marvin		F. Birely			Alice			220-54-4618			Mrs. Helen B. DeLawter			2111 Pine Valley Dr. 21093 Timonium, Md.							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.			16c. ADDRESS			16d. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH													
No														5 - 7 DAYS							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY:												#428 - CONGESTIVE HEART FAILURE									
IMMEDIATE CAUSE (a) 4029 Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.												DUE TO, OR AS A CONSEQUENCE OF #402 - HYPERTENSIVE CARDIOVASCULAR DISEASE									
(b) DUE TO, OR AS A CONSEQUENCE OF												10 - 15 yrs.									
(c)																					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY?									
												YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																
		P.M. 19																			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE										
22a. I certify that I took charge of the remains described above, held an												Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/>									
death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																					
ACTUAL SIGNATURE		TITLE (SPECIFY) DEPUTY M.D.										MEDICAL EXAMINER 217 WEST WASHINGTON STREET									
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS										DATE SIGNED Nov. 2, 1983									
EDWARD W. DITTO, III, M.D.		HAGERSTOWN, MARYLAND 21740																			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIUM			23d. LOCATION CITY OR TOWN			23e. STATE											
Burial		11/3/83		Bethel Church Cemetery			Cascade, R.D. 1			Washington Co. Md.											
24. FUNERAL DIRECTOR NAME		ADDRESS			17268			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE										
Judy Gano		50 S. Broad St. Waynesboro, Pa.						NOV. 8, 1983			J. George Cariel										
BP																					
DHMH - 17 (VR A15 ME (5)) 30M 7/73																					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at 301-767-2355.

## MEDICAL CERTIFICATION

STATE OF MARYLAND						3	3	1	2	4	4						
DEPARTMENT OF HEALTH AND MENTAL HYGIENE																	
CERTIFICATE OF DEATH																	
REG. NO. 11 22 83																	
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR					
Petuel			NMN	Brevil		11/22/83					83	5:58 P.M.					
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS						
Male		Black		June 6 DAY 1946		37			MONTHS	YEARS	MONTHS	HOURS					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Haiti		U.S.A.				Washington County			Hagerstown			Washington County		MD.			
13a. STATE Md.		13b. COUNTY Wash.		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 1028 F Noland Village			21740					
14. FATHER'S NAME			FIRST Edsria	MIDDLE NMN	LAST Brevil	15. MOTHER'S MAIDEN NAME			FIRST Edovil	MIDDLE NMN	LAST Unknown	21740					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
No			266-71-3585			Carol Brevil			1028 F Noland Village			21740					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))																	
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 5728																	
DUE TO, OR AS A CONSEQUENCE OF (b) <u>DISSEMINATED CRYPTOCOCCUS Neoforman</u>																	
DUE TO, OR AS A CONSEQUENCE OF (c) <u>ACQUIRED IMMUNE DEFICIENCY SYNDROME</u>																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		P.M.		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET				CITY OR TOWN		COUNTY		STATE					
22a. I certify that (I) (this hospital) attended the deceased from 11/17 19 83 to 11/22 19 83, that (I) (we) last saw the deceased alive on 11/22 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE <u>Dino J. DeSpiras</u> MD												DEGREE	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 11/22/83			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		23a. BURIAL, CREMATION, REMOVAL (SPECIAL)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN		23e. COUNTY					
Dino J. DeSpiras MD		703 Oak Hill Ave, Hagerstown, MD		11/23/83		Smithburg Creamatory		Smithburg		Wash.		Md.					
24. FUNERAL DIRECTOR NAME		ADDRESS		21780		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE									
Dennis L. Davis Smithburg, Md.						NOV 28 1983		John J. Conigli									



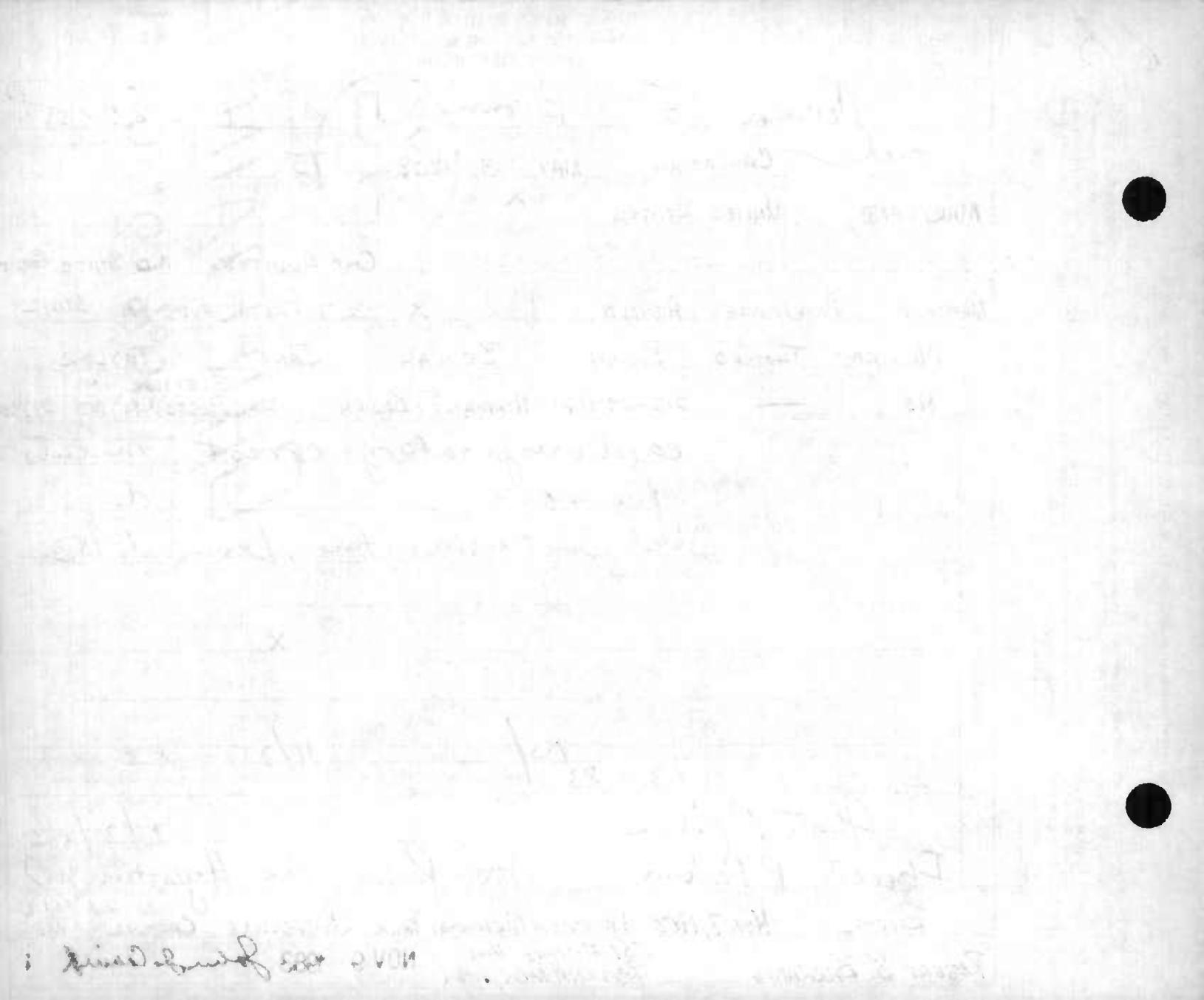
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified in order to have the death certificate certified by the medical examiner.

## MEDICAL CERTIFICATION

STATE OF MARYLAND										DEPARTMENT OF HEALTH AND MENTAL HYGIENE				CERTIFICATE OF DEATH				31245			
1 - FOR STATE REGISTRAR												REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)		FIRST			MIDDLE			LAST			2d. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR					
Norman E. Brown											11-3-83		355	P							
3. SEX		4. RACE						5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS						
Male		Caucasian						Month May Day 3 Year 1908			75		MONTHS		DAYS						
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?						8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH		MD.								
MARYLAND		UNITED STATES									Washington		Washingon								
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY					
Hagerstown		Western Maryland Center										Corr. Auditor				Md. State Gov.					
13a. STATE		13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS										
MARYLAND		Anne Arundel			Arnold			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			357 FRESHFIELDS LN. 21012										
14. FATHER'S NAME		FIRST			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME										
William Thomas Brown											Beulah Jane Taylor										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.						17. INFORMANT			ADDRESS										
No		212-09-1161						Norman F. Brown			ELEANOR LN. HAGERSTOWN, MD. 21740										
18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c). PART 1. DEATH WAS CAUSED BY										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
IMMEDIATE CAUSE (a) 1919 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, lost.										Minutes											
b) pneumonia DUE TO, OR AS A CONSEQUENCE OF c) malignant astrocytoma, brain										days 10/83											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a																					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED								20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE									
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 10/1 19 to 11/3 1983, to 11/3 1983, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 11/3 1983, and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.																					
22b. SIGNATURE Florentina P. Patoms		DEGREE								22c. DATE SIGNED 11/3/83											
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Florentina P. Patoms		22e. ADDRESS 1500 Penna. Ave Hagerstown MD																			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Nov. 7, 1983			23c. NAME OF CEMETERY OR CREMATORIAL LAKEVIEW MEMORIAL PARK			23d. LOCATION CITY OR TOWN Sykesville		23e. COUNTY Carroll		23f. STATE MD.									
24. FUNERAL DIRECTOR NAME ROBERT S. BARRANCO		25a. RITUAL Serenity Park, MD.						25b. DATE REC'D. BY REGISTRAR OR REGISTRAR'S SIGNATURE NOV 9 1983													



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury or other traumatic event, the medical examiner may be notified or sent.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												83	31246					
												REG. NO.						
1. FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR			
			George Mortimer			Bushey			11-23-83						6:30P M			
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS				
Male			White			Jan 8 1911			72			MONTHS	DAYS	HOURS	MIN.			
7a. BIRTHPLACE (COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			6. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH									
Maryland			U.S.A.						Washington									
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY									
Hagerstown			Western Maryland Center			Office Work			Planing Mill Co									
13a. STATE Md.			13b. COUNTY Wash.			13c. CITY OR TOWN Cavetown			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS P. O. Box 55			21720			
14. FATHER'S NAME FIRST Frank			MIDDLE E.			LAST Bushey Sr.			15. MOTHER'S M AIDEN NAME FIRST Ruby			MIDDLE J.			LAST Spielman			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT			18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 5723 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 5723 DUE TO, OR AS A CONSEQUENCE OF (b) <i>Sepsis</i> DUE TO, OR AS A CONSEQUENCE OF PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 chronic obstructive lung disease porttal hypertension			ADDRESS						
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)												
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE				
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from saw the deceased alive on above, (1) <input checked="" type="checkbox"/> (did) <input checked="" type="checkbox"/> view the body after death.			22b. DEGREE			22c. DATE SIGNED												
22d. ATTENDING PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS			22f. DATE SIGNED												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL Burial Nov 26, 1983 Rose Hill Cemetery			23d. LOCATION CITY OR TOWN Hagerstown, Wash. MD									
24. FUNERAL DIRECTOR Dennis Z. Davis Davis Funeral Home, Smithsburg, MD., 21783						25a. DATE REC'D. BY REGISTRAR NOV 28 1983			25b. REGISTRAR'S SIGNATURE John J. Conroy									

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached from us or the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 is marked or if item 18 shows any injury, or other traumatic event, then medical examiner must be notified at 301-247-8333.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												31247											
												REG. NO.											
1. FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST Hazel			MIDDLE unknown			LAST CALLIHAN			2a. DATE OF DEATH MONTH Nov. 4, 1983			2b. HOUR 3:30 A M					
3. SEX female			4. RACE white			5. DATE OF BIRTH MONTH Jan. 19, 1898			YEAR			6. AGE (IN YEARS LAST BIRTHDAY) 85			IF UNDER 1 YEAR MONTHS YRS.		IF UNDER 24 HRS MONTHS HOURS MIN.						
BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania			7b. CITIZEN OF WHAT COUNTRY? USA			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Washington			10. CITY OR TOWN OF DEATH Hagerstown			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Pennsylvania			13b. COUNTY Bedford			13c. CITY OR TOWN New Paris			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS Route 1			99999			MD					
14. FATHER'S NAME FIRST Albert			MIDDLE			LAST Miller			15. MOTHER'S MAIDEN NAME FIRST Naomi			MIDDLE			16. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO.			17. INFORMANT Jack Geisel F. H., Alum Bank, Pa. 15521		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 4292 IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 - 5 DAYS											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE											
{ DUE TO, OR AS A CONSEQUENCE OF (c)												15 - 25 YRS.											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																							
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>														
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC)			21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE								
22a. I certify that (I) <input checked="" type="checkbox"/> <input type="checkbox"/> attended the deceased from NOV. 1, 1983 to NOV. 4, 1983, to NOV. 4, 1983, that (I) <input checked="" type="checkbox"/> lost saw the deceased alive on NOV. 3, 1983, and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> <input type="checkbox"/> did <input type="checkbox"/> view the body after death.												22b. DATE SIGNED Nov. 4, 1983											
22b. SIGNATURE Edward W. Ditto, III, M.D.			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED Nov. 4, 1983			22d. PHYSICIAN'S NAME (TYPE OR PRINT) EDWARD W. DITTO, III, M.D.			22e. ADDRESS 217 WEST WASHINGTON STREET HAGERSTOWN, MARYLAND 21740								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) removal			23b. DATE Nov. 4, 1983			23c. NAME OF CEMETERY OR CREMATORIAL FISHERTOWN CEM.			23d. LOCATION FISHERTOWN, PA.														
24. FUNERAL DIRECTOR MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740						25a. DATE REC'D. BY REGISTRAR NOV 7 1983			25b. REGISTRAR'S SIGNATURE John J. Canfield														

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STRUCTURE SHOT

20021 RADAR AND OTHER SIGHTING

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TEST VOTED AGAINST

ANALYSTIC

OTTI GRANOS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Page 4 and 2 may be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, no medical certificate is required.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												31248				
REG. NO.																
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
Charles Eader Corderman												11	14	83	6:15p M	
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR		8. IF UNDER 3 HRS		
Male			White			MONTH 05 25 05			MONTH 78			MONTHS	DAYS	HOURS	MIN	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH				
Md			US									WASHINGTON				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)									12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY	
Hagerstown			WESTERN MARYLAND CENTER													
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS				
Md			Wash			Hagerstown						22 Tannery Lane 21795				
FATHER'S NAME FIRST			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME FIRST			MIDDLE			LAST	
Oscar			M.			Corderman			Bessie			C			Eader	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			18. CAUSE OF DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
No			173-03-2301			Joseph P. Corderman, Manassas, Va.			3109			Hemorrhagic Shock Hrs				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			(b)			DUE TO, OR AS A CONSEQUENCE OF Peptic Ulcer			DUE TO, OR AS A CONSEQUENCE OF Chronic Brain Syndrome			Nestling Yrs				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)										
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE		
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 8/25 1983 to 8/26 1983, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 11/14 1983, and that in (my) our opinion death occurred on the date and hour and from the causes stated above, (I) (we) did <input checked="" type="checkbox"/> not <input type="checkbox"/> view the body after death.																
22b. SIGNATURE			22c. DEGREE			22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. ADDRESS			22f. DATE SIGNED				
Drung S. Klein			M.D.			KUNG S. KIM			500 Penna Ave			Hagerstown, Md. 21740			11/14/83	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			COUNTY		STATE		
burial			Nov. 17, 1983			Rose Hill Cemetery			Hagerstown							
24. FUNERAL DIRECTOR NAME MINNICH FUNERAL HOME ADDRESS 415 E. Wilson Blvd., Hagerstown, Md. 21740																
25a. DATE REC'D. BY REGISTRAR <input type="checkbox"/> b. REGISTRAR'S SIGNATURE																
NOV 18 1983 <i>Spand &amp; Caselli</i>																

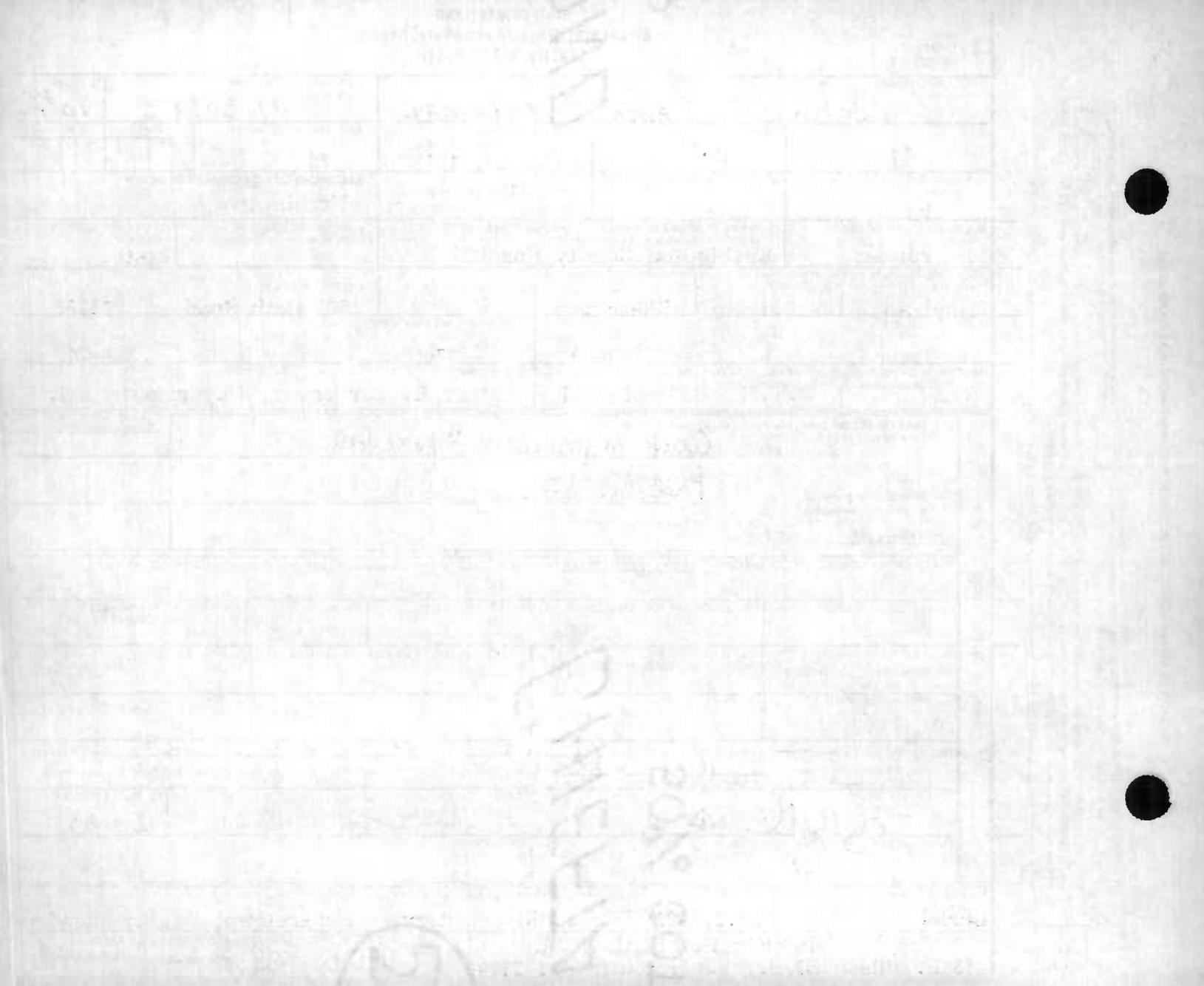
Philadelphia 202 81 1001

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director (page 1), it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the state Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner may be notified of same.

STATE OF MARYLAND 3 31249 DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH														
REG. NO.														
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR					
John EADER CORDERMAN						11/30/83			104 PM					
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		
M		white		Sept. 29, 1913			70			YRS.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Washington			MD.				
Maryland		USA												
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
Hagerstown		Washington County Hospital												
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS				
Maryland		Washington		Williamsport						102 Heth Road			21795	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST												
Oscar M. Corderman		Bessie Eader												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS							
Yes		W.W.II		214-09-0691			Esther B. Corderman, Hagerstown, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
5579 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										Acute Myocardial Infarction				
DUE TO, OR AS A CONSEQUENCE OF (b) Probable Ischemic bowel														
DUE TO, OR AS A CONSEQUENCE OF (c)														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
							YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
		P.M. 19												
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (the hospital) attended the deceased from 11-28, 1983, to 11-30, 1983, that (I) (we) lost saw the deceased alive on 11-30, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.														
22b. SIGNATURE MD		22c. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 12-1-83						
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL ROSE HILL CEMETERY			23d. LOCATION CITY OR TOWN			23e. COUNTY STATE				
		Dec. 3, 1983								Hagerstown, Wash., Maryland				
24. FUNERAL DIRECTOR NAME		24b. FUNERAL HOME MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE						
								DEC 5 1983			John J. Cawley			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												3 1 2 5 0								
												REG. NO.								
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR		
BERTHA H. COSS												NOVEMBER 06, 1983			4 P.M.					
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE			7. IF UNDER 1 YEAR			8. IF UNDER 24 HRS					
Female			white			MONTH DAY YEAR			IN YEARS (LAST BIRTHDAY)			79			MONTHS DAYS HOURS MIN.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			WASHINGT <sup>ON</sup> CO. MD.								
Md.			U.S.A.			NOV. 2 1904														
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			13b. COUNTY			13c. CITY OR TOWN			12b. KIND OF BUSINESS OR INDUSTRY					
Hagerstown			Washington County Hospital			Housewife			Md.			WASH.			Home					
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS			12c. ADDRESS					
Md.			WASH.			Hagerstown			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			111 W. Longmeadow Rd.			126 W. Longmeadow Rd.					
14. FATHER'S NAME			FIRST			LAST			15. MOTHER'S MAIDEN NAME			16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT		
Amos			M.			MARTIN			Amanda			NO			312-74-9323			Lewis M. Coss		
18. CAUSE OF DEATH PART I. DEATH WAS CAUSED BY:			ADDRESS												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
IMMEDIATE CAUSE (a) <u>ACUTE MYOCARDIAL INFARCTION, SUSPECTED</u>															1 DAY					
4100																				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.																				
(b) _____																				
DUE TO, OR AS A CONSEQUENCE OF																				
(c) _____																				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																				
DIABETIC KETONICOSIS, ACUTE KIDNEY FAILURE																				
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?											
None						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)														
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE					
22a. I certify that (I) this hospital) attended the deceased from on 11-06-83, 19_____, to 19_____, that (I/we) lost saw the deceased alive on 11-06-83, 19_____, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I/we) (did) (did not) view the body after death.																				
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN			MEDICAL DIRECTOR			STAFF PHYSICIAN			22c. DATE SIGNED					
Barry M. COTEN			M.D.												11-07-83					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			23e. ADDRESS			339 E. ANTIETAM ST.														
BARRY M. COTEN						HAGERSTOWN, MD, 21740														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORI			23d. LOCATION CITY OR TOWN			COUNTY			STATE					
Burial			Nov. 9, 1983			Reiff Church Cem.			Bear Creek - Wash. Co., Md.											
24. FUNERAL DIRECTOR NAME			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE														
Marvin Muller - Greencastle Pa.			NOV 9 1983			John C. Cawley														

2018-09-11

ГИБДД



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PAGE 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 1 2 3 4		
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI- MATED			MONTH	DAY	YEAR	2b. HOUR		
<i>Gertrude Bradford Crowther</i>						<input checked="" type="checkbox"/> 11/11 1983			12 PM	56		12 PM		
3. SEX		4 RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR. MONTHS DAYS	8. IF UNDER 24 HRS. HOURS MIN	2c. DATE PRONOUNCED DEAD			MONTH	DAY	YEAR	2d. HOUR	
female		white	Dec. 12, 1918 64	YRS.			<input checked="" type="checkbox"/> 11/11 1983			12 PM	56		12 PM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED			9. BALTIMORE CITY OR COUNTY OF DEATH			MD					
Ohio		U.S.A.				<i>Washington</i>								
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Hagerstown			Washington County Hospital			Housewife			Home					
13a. STATE Md.			13c. CITY OR TOWN Frederick		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS 14410 Brown Rd. 21780						
14. FATHER'S NAME FIRST George			MIDDLE	LAST Harwood	15. MOTHER'S MAIDEN NAME FIRST Mary			16. SOCIAL SECURITY NO. 006-10-6847			17. INFORMANT Mr. Harold E. Crowther Sabillasville, Md.			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) yes			16b. SOCIAL SECURITY NO. WW II			16c. ADDRESS			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Breast carcinoma 174</i> DUE TO, OR AS A CONSEQUENCE OF 1749 Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> lying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?								
						<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>														
ACTUAL SIGNATURE <i>Allen W. Duff, M.D.</i>			TITLE (SPECIFY) M.D. <i>Dept Asst</i>			MEDICAL EXAMINER			DATE SIGNED <i>11/11/83</i>					
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS <i>1610 Oak Hill Ave. Hagerstown</i>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE Nov. 12, 83			23c. NAME OF CEMETERY OR CREMATORIAL Smithsburg Crematory			23d. LOCATION CITY OR TOWN Smithsburg, Wash. Md.			STATE		
24. FUNERAL DIRECTOR <i>Dennis K. Davis</i> Davis Funeral Home						25a. DATE REC'D. BY REGISTRAR NON 16 1983			25b. REGISTRAR'S SIGNATURE <i>John G. Carroll</i>					

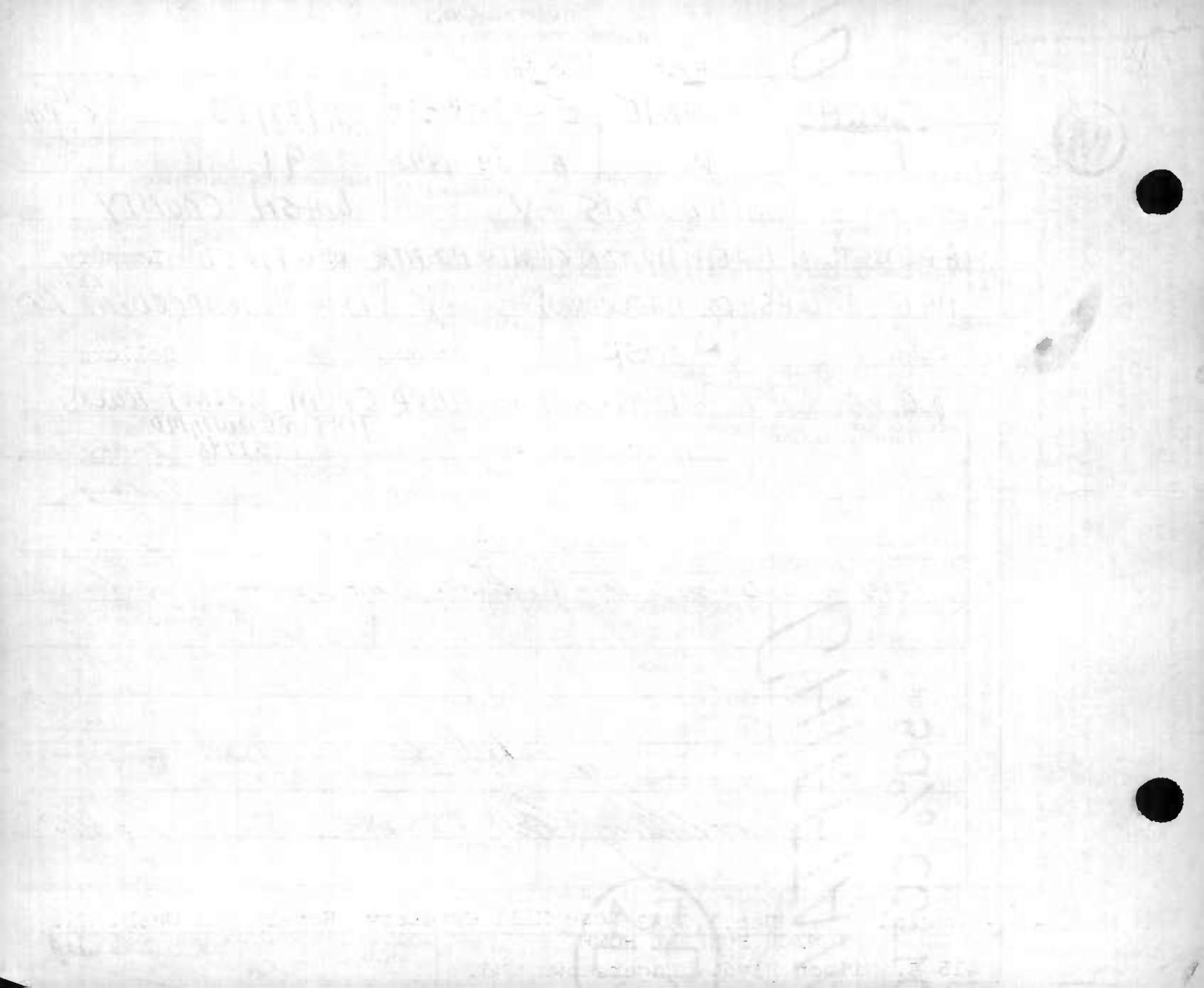
Wetland 0901104

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please return by the funeral director or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Page 1 and 2 should be filled within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked, or if item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND 3 DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH													
First MIDDLE											REG. NO.		
1 - FOR STATE REGISTRAR		3. DECEASED NAME (TYPE OR PRINT)		4. FIRST		5. MIDDLE		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR
		CRUM JENNIE ELIZABETH						11/29/83				1983	6:45 PM
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS			
F		W		MONTH 5 DAY 23 YEAR 1892		91 YRS.		MONTHS		DAYS		HOURS	
7a. BIRTHPLACE STATE OR FOREIGN West Virginia		7b. CITIZEN OF WHAT COUNTRY? UNITED STATES		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH WASH. COUNTY MD.							
10. CITY OR TOWN OF DEATH HAGERSTOWN		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WASHINGTON COUNTY HOSPITAL		12a. USUAL OCCUPATION Presser		12b. KIND OF BUSINESS OR INDUSTRY Laundry							
13a. STATE MD		13b. COUNTY WASH CO		13c. CITY OR TOWN HAGERSTOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 1735 BROADFORDING RD					
14. FATHER'S NAME FIRST John		15. MOTHER'S MIDDLE NAME LAST Sisk		16b. SOCIAL SECURITY NO. 215-48-2554		17. INFORMANT RICHARD CRUM WALNUT TOWERS		ADDRESS HAGERSTOWN, MD 21740					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Indirect agent</u> 4140 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>coronary arteriosclerosis</u> (c) <u>generalized arteriosclerosis</u>													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. <u>Arterial arteriosclerosis, chronic renal insufficiency, hypertension</u>													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY	STATE				
22a. I certify that (1) (this hospital) attended the deceased from saw the deceased alive on above, (1) (we) (did) (did not) view the body after death.		22b. SIGNATURE <u>Edgar S. Hager</u>		22c. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED 11/29/83							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE Dec. 1, 1983		23c. NAME OF CEMETERY OR CREMATORIAL Rose Hill Cemetery		23d. LOCATION CITY OR TOWN Hagerstown, Wash., Md.							
24. FUNERAL DIRECTOR NAME 415 E. Wilson Blvd., Hagerstown, Md.		25a. DATE REC'D. BY REGISTRAR DEC 2 1983		25b. REGISTRAR'S SIGNATURE <u>John J. Smith</u>									



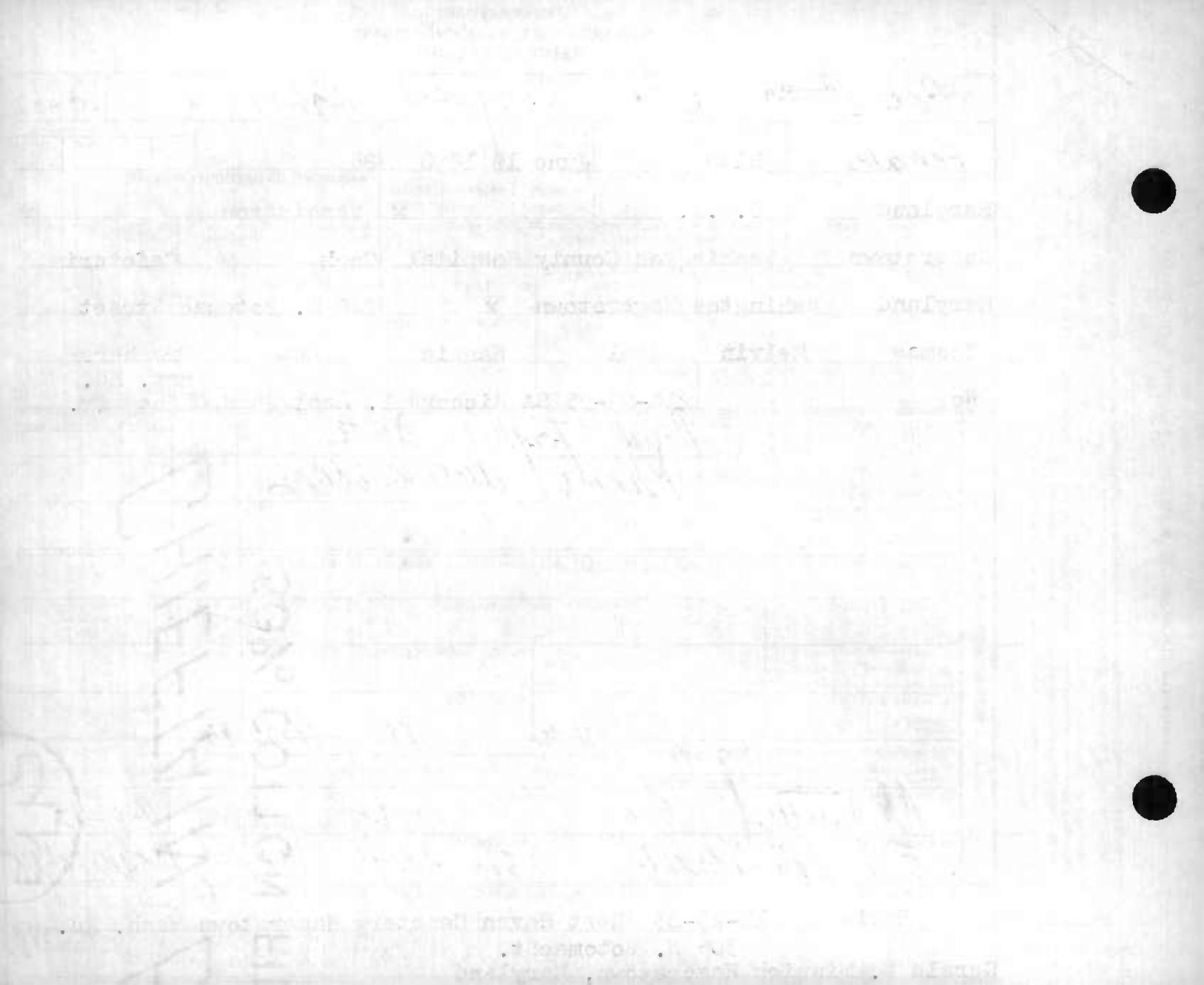
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH															
230. BURIAL, CREMATION, REMOVAL (SPECIFY)											231. DATE	232. NAME OF CEMETERY OR CREMATORIAL	233. LOCATION CITY OR TOWN	234. COUNTY	235. STATE
24. FUNERAL DIRECTOR NAME											250. DATE REC'D. BY REGISTRAR	251. REGISTRAR'S SIGNATURE			
1. DECEASED NAME (TYPE OR PRINT)											2. DATE OF DEATH	MONTH	DAY	YEAR	26. HOUR
Carrie M. M. Daley											11-21-83	3	21	1983	20 47 M
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS				
Female		White		June 18 1898			85		YEARS		MONTHS DAYS HOURS MIN.				
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH		10. CITY OR TOWN OF DEATH						
Maryland		U.S.A.					Washington		Hagerstown						
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY									
Washington County Hospital		Cook				Cafeteria									
13a. STATE		13b. COUNTY		13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS								
Maryland		Washington		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			240 S. Potomac Street								
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				17. INFORMANT							
Thomas		Nannie		16a. (YES, NO OR UNKNOWN)				17. ADDRESS							
Melvin		Lea		16b. (IF YES, GIVE WAR OR DATES)				17. Richard L. Reel 28 R Cheney Dr							
Reel		Brashers		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)				18b. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
4409				4409 Rheal Taylor Forte											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any.				18c. DUE TO, OR AS A CONSEQUENCE OF (b)				18d. DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET		CITY OR TOWN		COUNTY STATE					
22a. I certify that (I) (this hospital) afforded the deceased from 19 to 19, 19, that (I) (we) lost saw the deceased alive on 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.															
22b. SIGNATURE		22c. DEGREE				ATTENDING PHYSICIAN		MEDICAL DIRECTOR		STAFF PHYSICIAN		22d. DATE SIGNED			
ER. Lee Wadsworth												11-21-83			
22e. PHYSICIAN'S NAME (TYPE OR PRINT)		22f. ADDRESS				22g. ADDRESS				22h. ADDRESS					
Burial		11-23-83 Rest Haven Cemetery				582 South Street, Hagerstown, Md.				582 South Street, Hagerstown, Md.					
24. FUNERAL DIRECTOR NAME		305 N. Potomac St.				250. DATE REC'D. BY REGISTRAR				251. REGISTRAR'S SIGNATURE					
Gerald N. Minnich		Hagerstown, Maryland				NOV 28 1983				John J. Conard					



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF AN EXTENSION IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-1. RETAIN PAGES 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND. (21201) PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 254

1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE KNOWN OF ESTI- DEATH MATED		MONTH DAY YEAR			2b. HOUR	
Robert			Charles Deau			<input checked="" type="checkbox"/>		11 7 1983			M	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR.	8. IF UNDER 24 HRS.	MONTHS	DAYS	HOURS	MIN	2c. DATE PRONOUNCED DEAD		
male	white	Feb. 21 1928	55 yrs.							11 7 1983		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Wisconsin		USA					Washington County, MD.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
Hagerstown			Washington County Hospital						G.A.F.			
13a. STATE Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 1053 Carroll Heights Blvd. 21740				
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST									
Robert C. Deau			Beatrice Tober									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			
No			396-22-7242			Keith R. Deau, Hagerstown, Md.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY:  8147 IMMEDIATE CAUSE (a) <u>Multiple injuries</u> DUE TO, OR AS A CONSEQUENCE OF  Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> <u>lying cause lost.</u>  (b) _____ DUE TO, OR AS A CONSEQUENCE OF  (c) _____												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?						
									YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR <input checked="" type="checkbox"/> MONTH DAY YEAR 8:37 P.M. 11 7 83			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Pedestrian struck by auto						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) road			21f. LOCATION STREET Northern Ave			CITY OR TOWN Hagerstown	COUNTY Wash.	STATE Md.	
22a. I certify that I took charge of the remains described above, held on death resulted from <input type="checkbox"/> Natural cause <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion									
ACTUAL SIGNATURE						TITLE (SPECIFY)						
EXAMINER'S NAME (TYPE OR PRINT)			Thomas D. Smith, M.D.			M.D. Deputy Chief MEDICAL EXAMINER			DATE SIGNED 11/8/83			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE cremation Nov. 9, 1983			23c. NAME OF CEMETERY OR CREMATORY Smithsburg Crematorium			23d. LOCATION CITY OR TOWN Smithsburg, Wash., Maryland			
24. FUNERAL DIRECTOR NAME ADDRESS			25a. DATE REC'D. BY REGISTRAR NOV 14 1983			25b. REGISTRAR'S SIGNATURE John J. Conner						
MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740												

BP \_\_\_\_\_

DHMH - 17  
(VR A15 ME (5))  
20M 4/B2

Wichita Falls, Texas

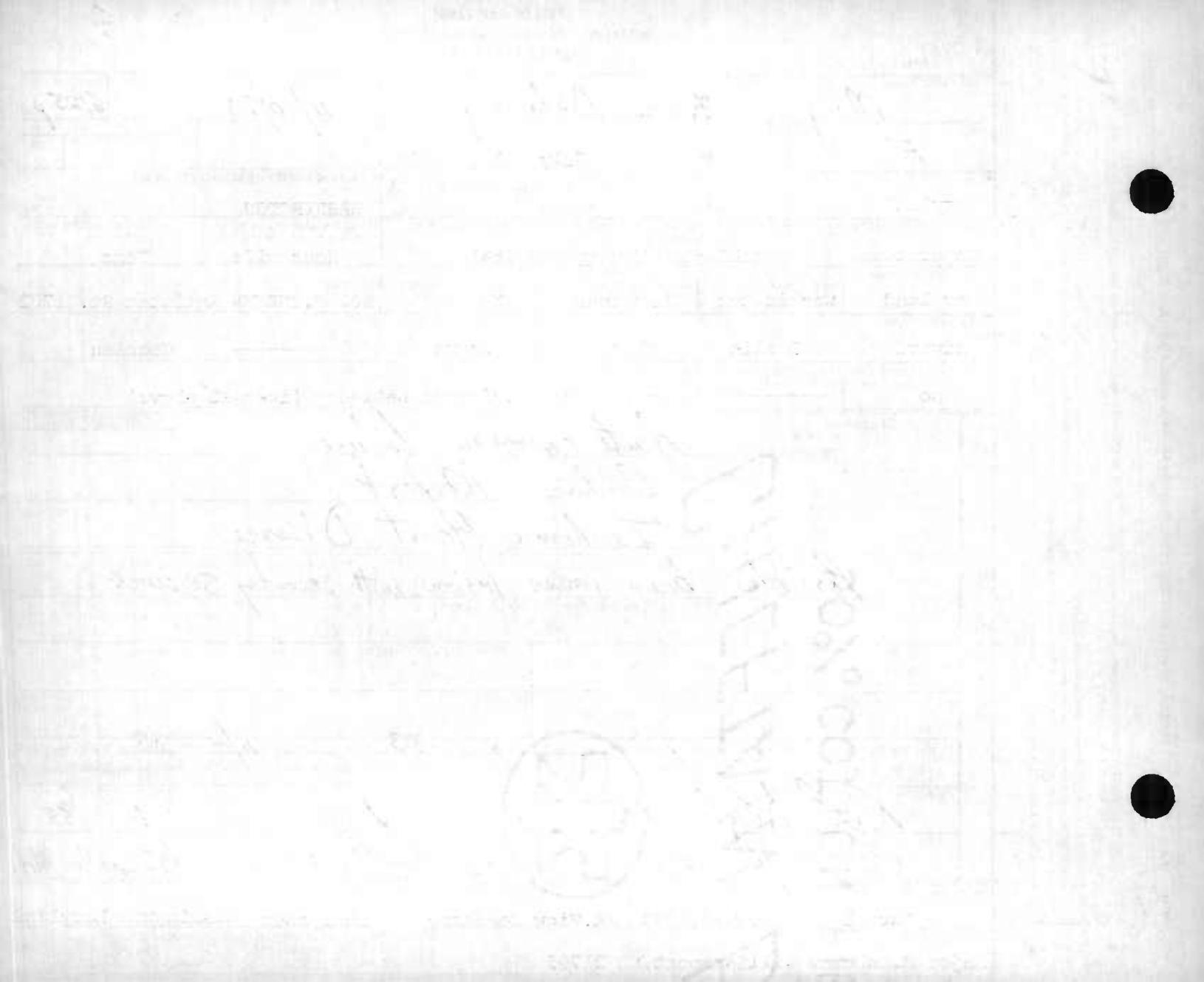
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner may be notified in accordance with the law.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										31255			
										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR				
Mary			Kathryn DeLauney			11/10/83			6:25 PM				
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS	
F		W		July 14, 1900			83 YRS.			MONTHS		DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			10. CITY OR TOWN OF DEATH			
Maryland		USA					WASHINGTON			Hagerstown			
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY					
Washington County Hospital				Housewife				Home					
13a. STATE Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Sharpsburg			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 103 E. Antietam St. 21782			
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST										
Edward Leslie Clipp			Laura Geaslen										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		18. CAUSE OF DEATH PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
no		215-07-8877B		R. Vincent DeLauney (item 13 above)		Acute coronary failure							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)		DUE TO, OR AS A CONSEQUENCE OF Cardiac Arrest									
		(c)		DUE TO, OR AS A CONSEQUENCE OF Ischemic Heart Disease									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										Possible brain mass lesion with secondary seizures.			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from 8-10-83 to 11-10-83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.										22c. DATE SIGNED 11/10/83			
22b. SIGNATURE R.L. Rugar MD		22c. DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>									
22d. PHYSICIAN'S NAME (TYPE OR PRINT) R.L. Rugar MD		22e. ADDRESS 100 Geeting Lane Keedysville, Md.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Nov. 13, 1983		23c. NAME OF CEMETERY OR CREMATORIAL Mt. View Cemetery		23d. LOCATION CITY OR TOWN Sharpsburg		COUNTY		STATE Washington Maryland			
24. FUNERAL DIRECTOR NAME Major M. Osborne Williamsport, MD 21795		ADDRESS		25a. DATE REC'D. BY REGISTRAR NOV 14 1983		25b. REGISTRAR'S SIGNATURE John J. Conroy							

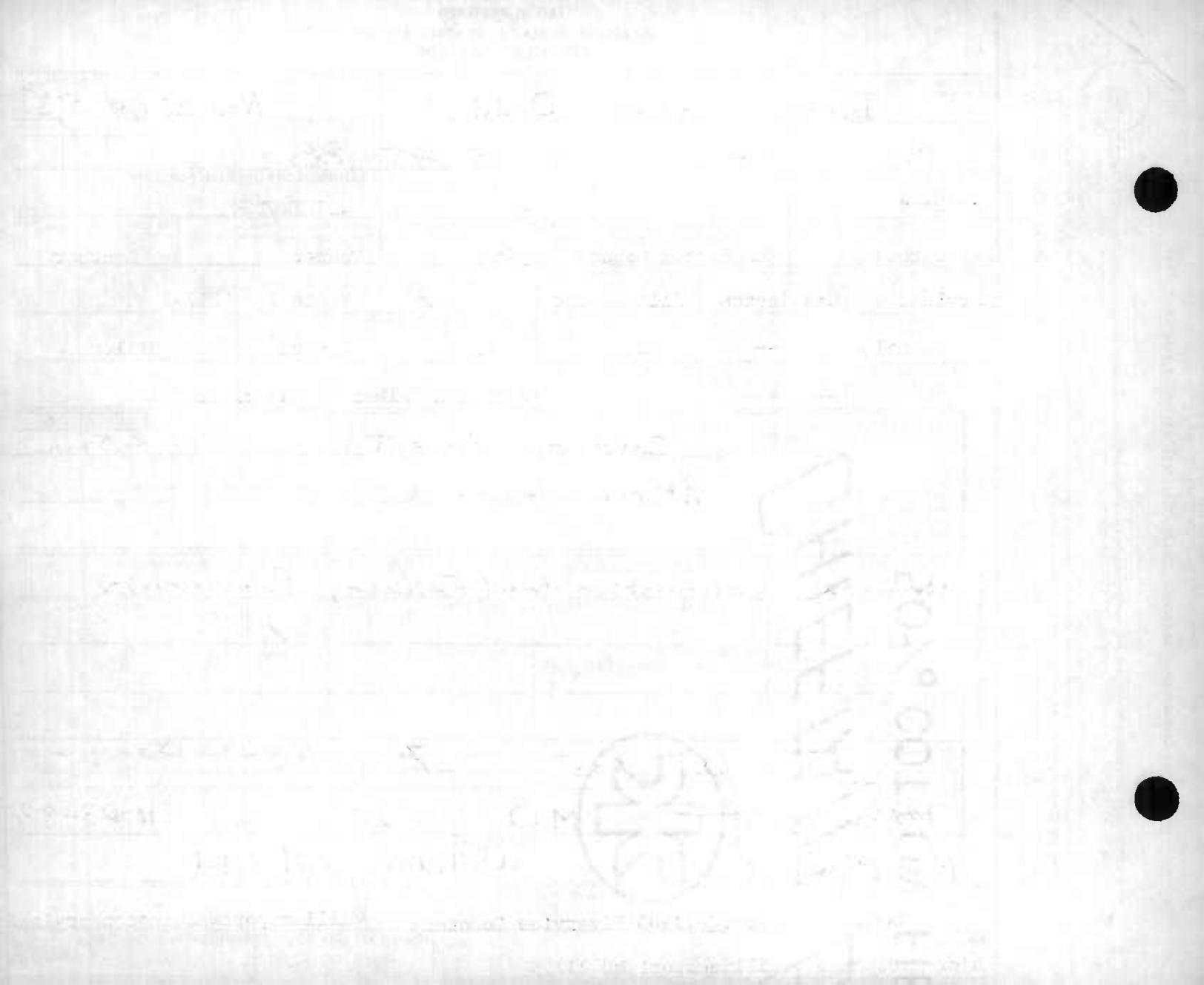


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please 4 copy on  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, please attach this to the burial/transit permit. Then please remove carbon papers. Page 1 and 2 should be filed within 72 hours after death  
 with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner should be notified or called.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.			
1. FOR STATE REGISTRAR			2a. DATE OF DEATH							2b. HOUR			
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	MONTH	DAY	YEAR	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS DAYS	HOURS	MIN.	
Isaac Albert Dodd						9	25	1895	88		5	28	
3. SEX			4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)					
Male			Cauc		MONTH	DAY	YEAR	88					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland			USA					WASHINGTON					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)							12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY
Hagerstown			Washington County Hospital							Tanner			Leather
13a. STATE			13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
Maryland			Washington		Williamsport			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Route 1 21795			
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST		
Samuel			-----		Dodd	Anne			-----	Ledora	Miller		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS					
no			(If Yes, give war or dates)		Patricia Walker			Waynesboro, PA					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
4409 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										< 5 min			
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Atherosclerosis</u>													
DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED							20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED							20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED AT HOME <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19 <u>80</u> , to <u>11-23</u> 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>11-22</u> 19 <u>83</u> , and that in (my) <u>his</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>we</u> (did) (did not) view the body after death.										22c. DATE SIGNED <u>11-23-83</u>			
22b. SIGNATURE <u>M E Byrkit</u>			DEGREE <u>MD</u>							ATTENDING PHYSICIAN	MEDICAL DIRECTOR	STAFF PHYSICIAN	
22c. PHYSICIAN'S NAME (TYPE OR PRINT) <u>M E Byrkit</u>			22d. ADDRESS <u>Williamsport MD</u>										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN		COUNTY	STATE		
Burial			Nov. 26, 1983		Riverview Cemetery			Williamsport		Washington	Maryland		
24. FUNERAL DIRECTOR NAME			25a. DATE REC'D. BY REGISTRAR							25b. REGISTRAR'S SIGNATURE			
Major M. Osborne										John J. Conigli			
ADDRESS			ADDRESS							ADDRESS			
Williamsport, MD 21795										Nov 28 1983			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and executed, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

## MEDICAL CERTIFICATION

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 31257

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR			
HAZEL K. EATON						11-1-83				8 30 PM M			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)				IF UNDER 1 YEAR			
Female		White		MONTH	DAY	YEAR	88	MONTHS	YEARS	IF UNDER 24 HRS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8		9. BALTIMORE CITY OR COUNTY OF DEATH				MD.			
Uniontown, PA.		USA		MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		Washington							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY					
Boonsboro		Falkney-Keedy Memorial Home		Asst. Per. Dir. Nat. B. of Standards									
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS					
MD.		Montgomery		Silver Spring		YES <input type="checkbox"/> NO <input type="checkbox"/>		815 THAYER AVE. 20910					
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME		ADDRESS					
George				Kefover		MAHALA		Hayden					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
UNKNOWN		220-34-8017		Lori J. THOMPSON LPN		Smithsburg, MD							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>cardiac arrest</i> 4149 DUE TO, OR AS A CONSEQUENCE OF (b) <i>ischemic heart disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any. DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. 19a. DATE OF OPERATION													
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>19</i> to <i>19</i> , that (I) (we) last saw the deceased alive on <i>19</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <i>Q. A. Khan</i>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 11/2/83			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Abdul WATTHEED, MD</i>		22e. ADDRESS <i>1600 Oak Hill Ave. Hagerstown, MD 21740</i>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>11/4/83</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Rest Haven Cemetery</i>		23d. LOCATION CITY OR TOWN <i>Hagerstown</i>		COUNTY <i>Wash.</i>		STATE <i>Md.</i>			
24. FUNERAL DIRECTOR NAME <i>Rest Haven Funeral Chapel, Inc.</i>						25a. DATE REC'D. BY REGISTRAR NOV 14 1983		25b. REGISTRAR'S SIGNATURE <i>John C. Cawley</i>					
1601 Pennsylvania Ave. Hagerstown, MD													



W. D. B. 6000 ft. above sea level.

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be

## TO HOSPITAL OR ATTENDING PHYSICIAN. The

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be resubmitted by the hospital or attending physician.

with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												
1 - FOR STATE REGISTRAR											REG. NO. 31258	
1. DECEASED NAME (TYPE OR PRINT)			FIRST Sadie		MIDDLE Mae		LAST Edleblute		2a. DATE OF DEATH MONTH DAY YEAR April 21, 1919		2b. HOUR 4:18 p.m.	
3. SEX Female			4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR April 21, 1919		6. AGE IN YEARS (LAST BIRTHDAY) 64 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Boonsboro, Md.			7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington		10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital	
12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Washington		13c. CITY OR TOWN Keedysville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Rfd. 1 Box 254		12b. KIND OF BUSINESS OR INDUSTRY Own Home	
14. FATHER'S NAME FIRST John			MIDDLE Christian		LAST Kline		15. MOTHER'S MAIDEN NAME FIRST Maude		MIDDLE Alice		LAST Greenwalt	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 217-10-3030		17. INFORMANT Mr. Norman H. Edleblute, Keedysville, Md.		18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		ADDRESS Rfd. 1 Box 254			
<p>18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)</p> <p>PART 1. DEATH WAS CAUSED BY:</p> <p>IMMEDIATE CAUSE (a) <u>Cardiac arrest</u></p> <p>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Premature Ventricular Contraction</u>, <u>Sudden</u></p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</p> <p>DUE TO, OR AS A CONSEQUENCE OF (c) <u>Chronic Angina</u></p>												
<p>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (e.g. <u>Obesity</u>)</p>												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE		
<p>22a. I certify that (I) (this hospital) attended the deceased from <u>18/10/83</u> to <u>7/19/83</u>, that (I) (we) last saw the deceased alive on <u>18/10/83</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.</p>												
22b. SIGNATURE <u>R.L. Ruzler</u>		22c. DEGREE <u>MD</u>		22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22e. DATE SIGNED						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>R.L. Ruzler</u>		22e. ADDRESS <u>100 Beeting Lane</u>		23d. LOCATION CITY OR TOWN <u>Boonsboro</u>		23e. COUNTY <u>Wash. Co.</u>		23f. STATE <u>Md.</u>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>11-18-83</u>		23c. NAME OF CEMETERY OR CREMATORIAL <u>Boonsboro Cemetery</u>		23d. LOCATION CITY OR TOWN <u>Boonsboro</u>				23e. COUNTY <u>Wash. Co.</u>		
24. FUNERAL DIRECTOR NAME <u>John H. Bast, Jr.</u>		ADDRESS <u>Boonsboro, Md. 21713</u>		25a. DATE REC'D. BY REGISTRAR <u>NOV 21 1983</u>		25b. REGISTRAR'S SIGNATURE <u>John J. Conard</u>						

СИВІС МІКРОСАМОВІ РІВНЯННЯ ВІДНОСИТИ

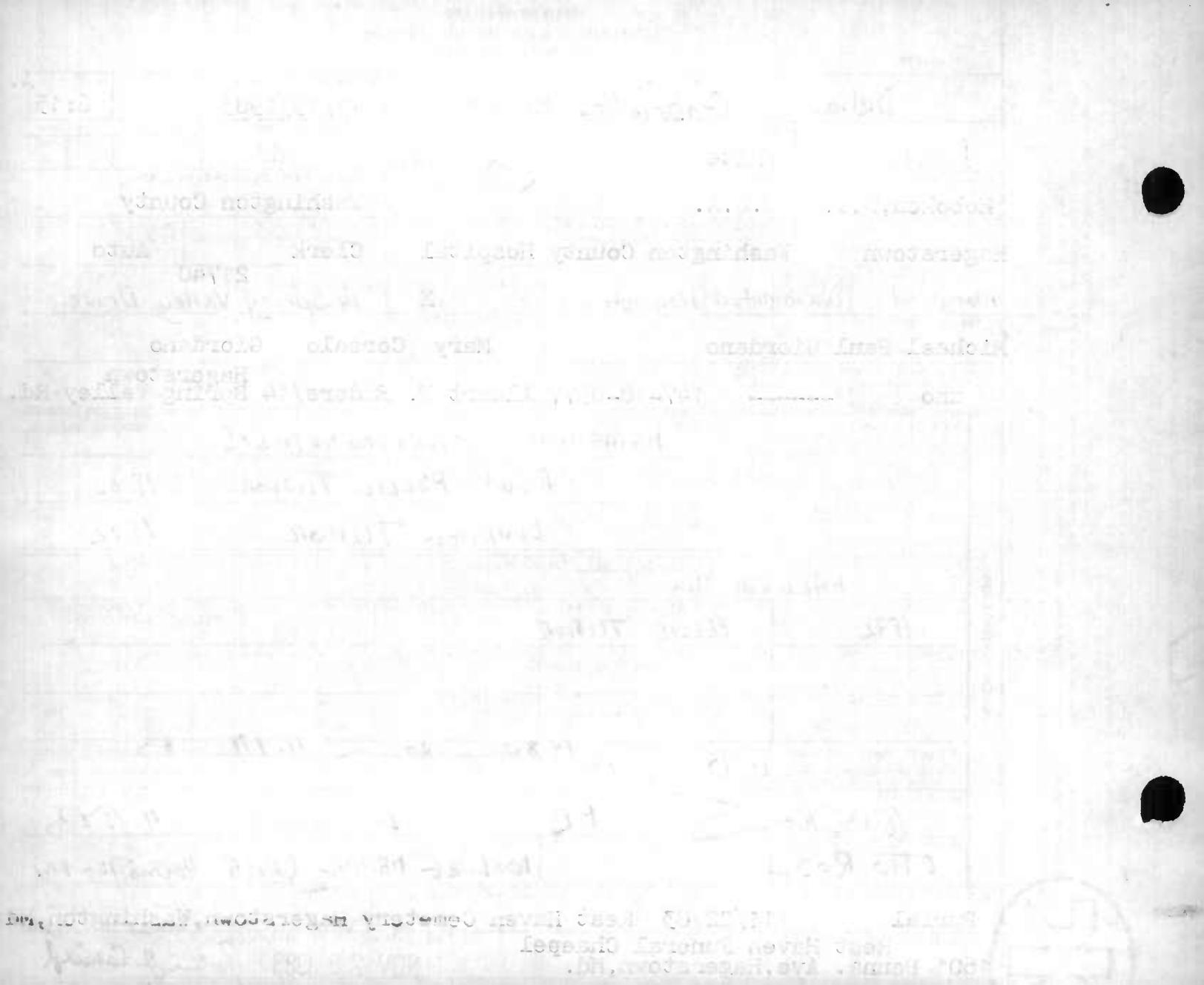
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the Burial Permit. Then please remove carbon copies. Pages 4 and 5 should be used within 72 hours of death.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 3 1 2 5 9				
1 - STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR 11/19/1983									2b. HOUR A. 6:15M				
1. DECEASED NAME (TYPE OR PRINT) <i>Delia Gabriella Enders</i>			MIDDLE			LAST			6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS.			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.				
3. SEX female			4. RACE White			5. DATE OF BIRTH MONTH 11 DAY 2 YEAR 1922			7. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Washington County MD.	
10. CITY OR TOWN OF DEATH Hagerstown			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital									12a. USUAL OCCUPATION Clerk			12b. KIND OF BUSINESS OR INDUSTRY Auto	
13a. STATE Maryland			13b. COUNTY Washington			13c. CITY OR TOWN Hagerstown			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS 21740 14 Spring Valley Drive				
14. FATHER'S NAME FIRST Michael Paul Giordano			15. MOTHER'S MAIDEN NAME FIRST Mary Corealo MIDDLE Giordano LAST													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b. SOCIAL SECURITY NO. 147-18-0577			17. INFORMANT Albert F. Enders			ADDRESS Hagerstown			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1990 METASTATIC CARCINOMATOSIS			19. DUE TO, OR AS A CONSEQUENCE OF (b) RIGHT PELVIC TUMOR 1982			20. DUE TO, OR AS A CONSEQUENCE OF (c) OVARIAN TUMOR 1972										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a. Hematoma.																
19a. DATE OF OPERATION 1982			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED PELVIC TUMOR.			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE										
22a. I certify that (I) (this hospital) attended the deceased from 1980, 1980, to 1983, 1983, that (I) (we) last saw the deceased alive on 1983, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																
22b. SIGNATURE <i>Enders</i>			22c. DEGREE 70			22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. DATE SIGNED 11/1983							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) OTTO ROZA			22e. ADDRESS 100 LONG MEADOW DRIVE HORNBECK MD.													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 11/22/83			23c. NAME OF CEMETERY OR CREMATORIAL Rest Haven Cemetery			23d. LOCATION CITY OR TOWN Hagerstown, Washington, Md.			25a. DATE REC'D. BY REGISTRAR NOV 28 1983		25b. REGISTRAR'S SIGNATURE <i>John J. Conroy</i>		
24. FUNERAL DIRECTOR NAME Rest Haven Funeral Chapel ADDRESS 1601 Penna. Ave. Hagerstown, Md.																



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner should be notified before the death certificate is signed.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										31260	
										REG. NO.	
1 - FOR STATE REGISTRAR											
I. DECEASED NAME (TYPE OR PRINT)		Elizabeth FIRST ELIZABETH MIDDLE Virginia FLANARY				2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR
SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS	
Female		White		MONTH 10 DAY 29 YEAR 22		61		MONTHS		DAYS HOURS MIN.	
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		Washington MD.			
W. Virginia 21740		U.S.A.				Washington					
10. TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
33 11		Washington County Hospital 21740		housekeeper		own home		21740			
13. STATE Maryland		13b. COUNTY Washington		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1427 Kensington Drive					
14. FATHER'S NAME Bennie		15. MOTHER'S MAIDEN NAME Pearl						LAST Hanlin			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS					
No		none 215-14-2498		Mrs. Peggy Ott		Emmitsburg, MD					
18. CAUSE OF DEATH: Enter only one cause per line for 1a, 1b, and 1c. PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRO-VASCULAR ACCIDENT</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4360</u> 6 DAYS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>HYPERTENSION; DIABETES MELLITUS</u>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <u>NONE</u>											
19a. DATE OF OPERATION <u>NONE</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (1) this hospital attended the deceased from <u>NOVEMBER 21, 1983</u> to <u>NOVEMBER 30, 1983</u> , that (1) (we) lost saw the deceased alive on <u>NOVEMBER 30, 1983</u> and that in (1) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) did not view the body after death.											
22b. SIGNATURE <u>BARRY M. COLTON</u>		DEGREE <u>MD</u>				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>12-01-83</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>BARRY M. COLTON</u>		22e. ADDRESS <u>339 E. ANTIGUA ST.</u>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE <u>12/3/83</u>		23c. NAME OF CEMETERY OR CREMATORIAL Lutheran Cemetery		23d. LOCATION CITY OR TOWN <u>UNIONTOWN</u>		COUNTY <u>CARROLL</u>		STATE <u>MD</u>	
24. FUNERAL DIRECTOR NAME <u>D. J. Hartler</u>		ADDRESS <u>Union Bridge, Md.</u>		25a. DATE REC'D. BY REGISTRAR <u>DEC 5 1983</u>		25b. REGISTRAR'S SIGNATURE <u>John J. Cawie</u>					

Group 11 simple machines

15 25 35 45 55 65



Newton's 3 laws

and the law of gravitation

using machines

Newton's 3 laws

of motion

and the law of gravitation

using machines

Newton's 3 laws

of motion

and the law of gravitation

using machines

Newton's 3 laws

of motion

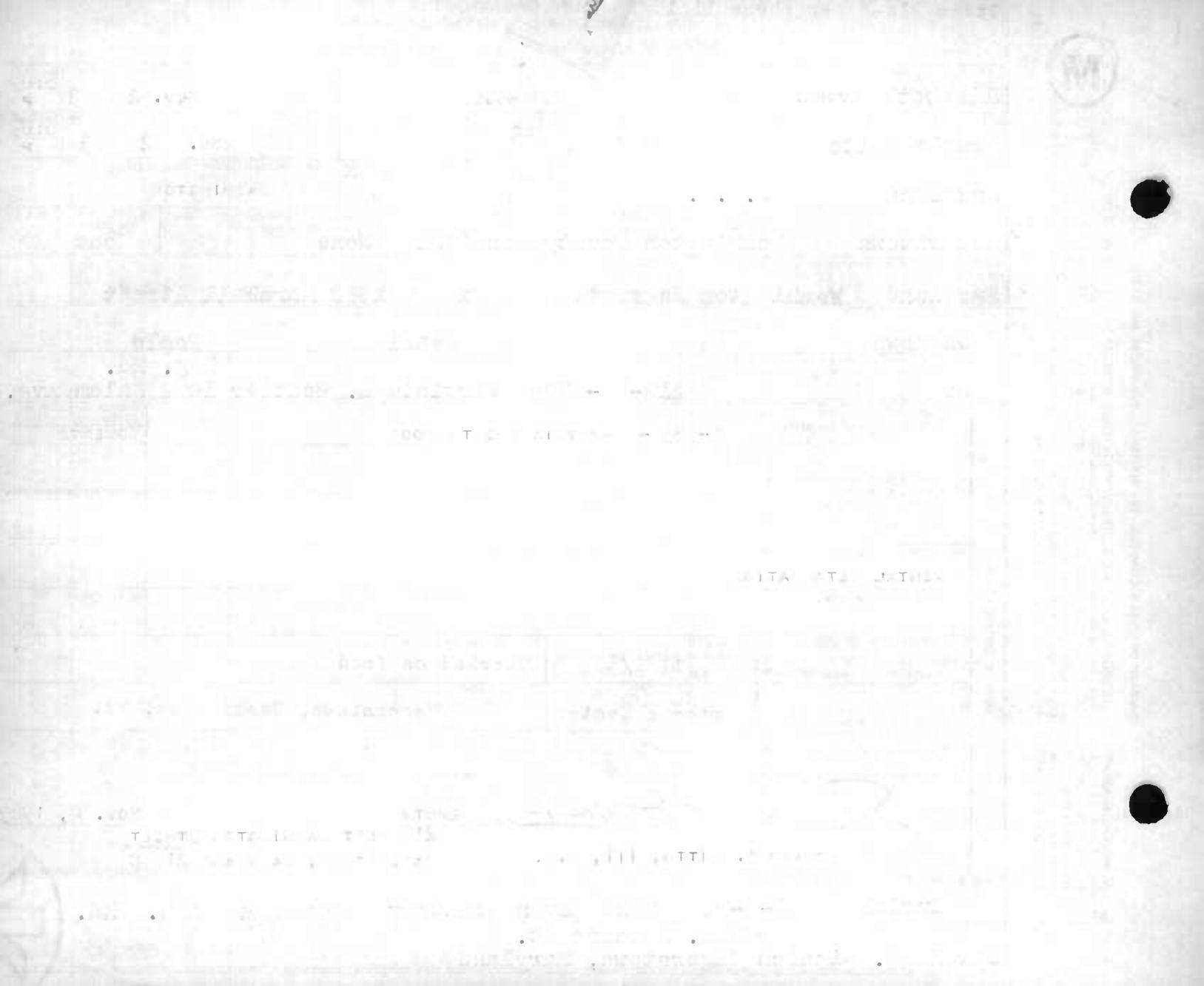
and the law of gravitation

using machines

Newton's 3 laws

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 8, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3, RETAIN PAGE 5 FOR YOUR FILE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND. 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI- DEATH MATED			MONTH	DAY	YEAR	2b. HOUR 6:09 P.M.	
Elizabeth YVONNE					FOGLE	<input type="checkbox"/>			Nov.	2	1983		
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR.	8. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.	2c. DATE PRONOUNCED DEAD			MONTH	DAY	YEAR	2d. HOUR 6:09 P.M.	
Female	White	2 20 1937	46 yrs			<input type="checkbox"/>			Nov.	2	1983		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED WIDOWED	NEVER MARRIED DIVORCED	9. BALTIMORE CITY OR COUNTY OF DEATH			WASHINGTON			
Maryland		U.S.A.			<input checked="" type="checkbox"/>	<input type="checkbox"/>							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
Hagerstown		Washington County Hospital					None			None			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS			21740		
Maryland		Washington		Hagerstown		<input checked="" type="checkbox"/>		1380 Marshall Street					
14. FATHER'S NAME FIRST		MIDDLE		LAST	15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		16. FOGLE				
Unknown					Pearl				Hag. Md.				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS		18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		21740			
No		218-76-6709		Virginia L. Beitler		1002 Salem Ave.		<input type="checkbox"/> MOMENTS					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) N-933 - ASPHYXIA DUE TO FOOD													
<p>9110 Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.</p> <p>(b) _____ DUE TO, OR AS A CONSEQUENCE OF</p> <p>(c) _____</p>													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). MENTAL RETARDATION													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY?						
							YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 11/2/83 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		Chocked on food							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Potomac Center		21f. LOCATION STREET		CITY OR TOWN		Hagerstown, Washington		COUNTY	STATE		
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE <i>Edward W. Ditto, M.D.</i>		TITLE (SPECIFY) DEPUTY		MEDICAL EXAMINER 217 WEST WASHINGTON STREET		DATE SIGNED		Nov. 4, 1983					
EXAMINER'S NAME (TYPE OR PRINT)		EDWARD W. DITTO, III, M.D.		ADDRESS		HAGERSTOWN, MARYLAND 21740							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		23e. COUNTY		23f. STATE			
Burial		11-4-83		Rest Haven Cemetery		Hagerstown Wash. Md.							
24. FUNERAL DIRECTOR NAME		305 N. Potomac St.		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
Gerald N. Minnich		Hagerstown, Maryland		NOV 7 1983		<i>John J. Coughlin</i>							
BP													
DHMH - 17 (VR A15 ME (5))													
20M 4/82													



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please move carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND 3 3 1 2 6 2 DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH														
1 - FOR STATE REGISTRAR			REG. NO.											
mildred			11-10-83											
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE			LAST			2a. DATE OF DEATH MONTH DAY YEAR					
mildred			Imogene			Forcino			11-10-83					
2. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.					
Female			white			6 13 07			76 YRS.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.					
10. CITY OR TOWN OF DEATH Hagerstown			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife			12b. KIND OF BUSINESS OR INDUSTRY 21740					
13a. STATE Maryland			13b. COUNTY Washington			13c. CITY OR TOWN Hagerstown			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 517 Liberty Street		
14. FATHER'S NAME FIRST Guy MIDDLE			LAST Shilling			15. MOTHER'S MAIDEN NAME Beatrice								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. 213-10-6795B			17. INFORMANT			ADDRESS					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4249 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			DUE TO, OR AS A CONSEQUENCE OF (b) Cardiac Arrest			DUE TO, OR AS A CONSEQUENCE OF (c) Valvular Heart Disease						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AI WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from 10/4/83 to 10/9/83, 1983, to 10/9/83, 1983, that (I) (we) last saw the deceased alive on 11/9/83, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE Francesco L. Andrade			DEGREE MP			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 11/10/83					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Francesco L. Andrade			22e. ADDRESS 363 S. Cleveland Ave. Hagerstown, Md.											
23a. BURIAL, CREMATION, REMOVAL SPECIAL burial			23b. DATE Nov. 14, 1983			23c. NAME OF CEMETERY OR CREMATORIAL Cemetery Cedar Lawn Mem. Park			23d. LOCATION CITY OR TOWN Hagerstown, Wash., Md. STATE					
24. FUNERAL DIRECTOR NAME MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740						25a. DATE REC'D. BY REGISTRAR NOV 16 1983			REGISTRAR'S SIGNATURE John G. Covert					



Санкт-Петербургский государственный  
технический университет

Библиотека 2281 том

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Please remove carbon paper. Page 2 should be filed within 7 days of death.

IMPORT ANTI: If Item 21 is marked as 'No', show any injury, or other traumatic event, this medical examiner will be notified.

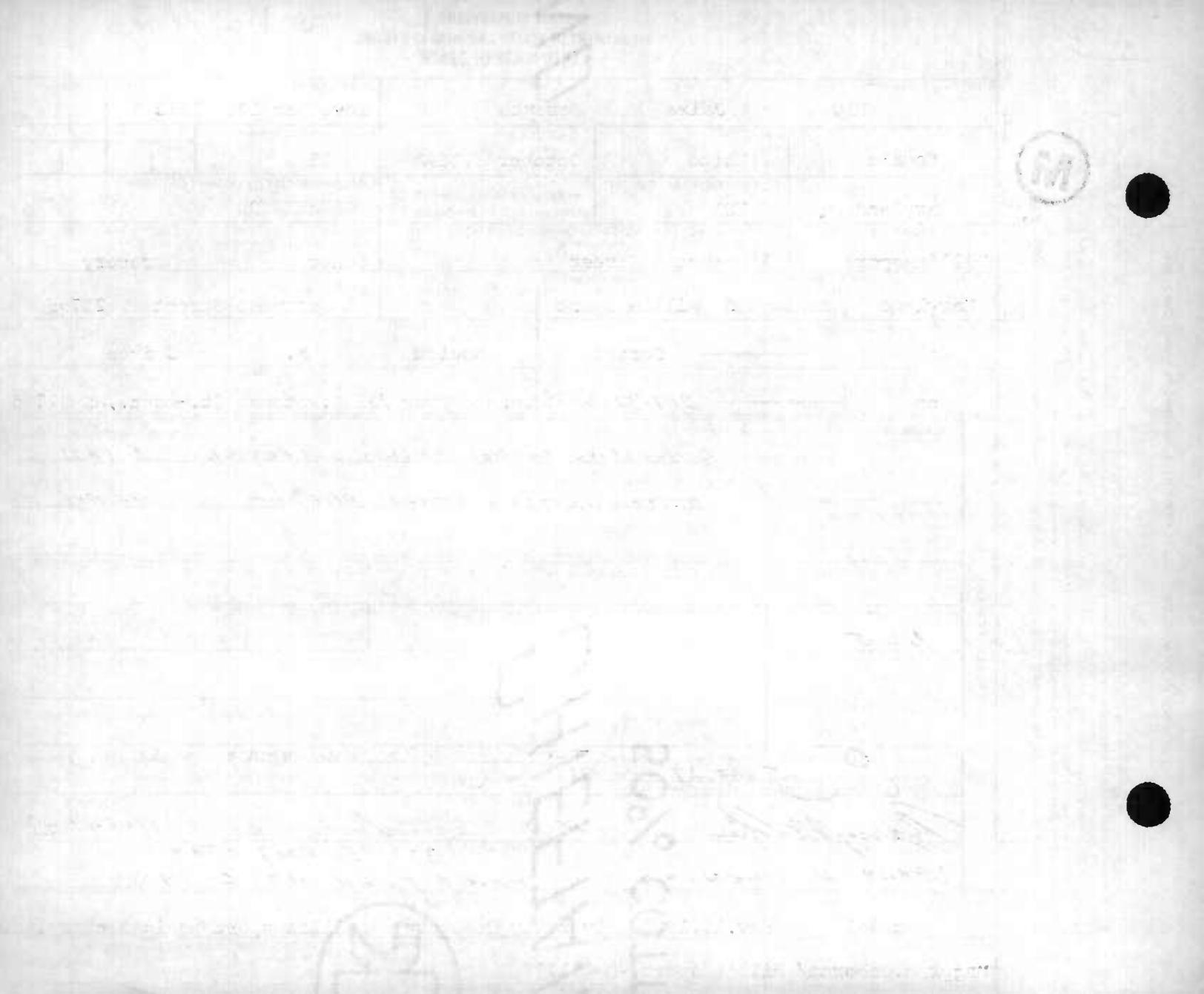
## MEDICAL CERTIFICATION

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

3 1 2 6 3

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST Flo	MIDDLE Jaira	LAST Forsyth	2a. DATE OF DEATH MONTH November	DAY 12, 1983	YEAR REG. NO.	2b. HOUR M	
3. SEX Female			4. RACE White		5. DATE OF BIRTH MONTH October	DAY 3, 1892	YEAR 91	6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.	
7. BIRTH PLACE (STATE OR FOREIGN COUNTRY) Maryland			7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH WASHINGTON			MD.	
11. CITY OR TOWN OF DEATH Williamsport			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1 Monument Street			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Owner			12b. KIND OF BUSINESS OR INDUSTRY Grocery	
13a. STATE Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Williamsport		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 1 Monument Street 21795		
FATHER'S NAME FIRST Caleb			MIDDLE -----		LAST Forsyth	15. MOTHER'S MAIDEN NAME FIRST Louisa			MIDDLE A.	LAST Shives
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 217-32-5338			17. INFORMANT Donald Drury/33 E. Potomac St. Wmspt., MD 21795			ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CONGESTIVE CARDIAC FAILURE, SUSPECTED</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 DAYS	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4140			DUE TO, OR AS A CONSEQUENCE OF (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u>						YEARS	
DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION None			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (1) (this hospital) attended the deceased from <u>JULY 19 79</u> to <u>NOVEMBER 19 83</u> , that (1) (we) last saw the deceased alive on <u>JUNE 27 19 83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) did (did not) view the body after death.										
22b. SIGNATURE <u>BARRY M. COHEN, MD</u>			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 11-14-83		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BARRY M. COHEN, MD			22e. ADDRESS 339 E. ANTIETAM ST HAGERSTOWN MD, 21740							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Nov. 15, 1983		23c. NAME OF CEMETERY OR CREMATORIAL Riverview Cemetery		23d. LOCATION CITY OR TOWN Williamsport		STATE Washington	
24. FUNERAL DIRECTOR NAME Major M. Osborne/ Williamsport, MD 21795			25a. DATE REC'D. BY REGISTRAR NOV 16 1983			25b. REGISTRAR'S SIGNATURE <u>John G. Lohr</u>				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 days with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified at

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.				
1 - FOR STATE REGISTRAR		LAST								2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		Frankenberry		5-28-1904		11-1-83		3 40		
William		B.				FRANKENBERRY		MONTH DAY YEAR		MONTHS DAYS		HOURS MIN.		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)								
M (Male)		W (White)		5-28-1904		79								
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8		MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		Washington County MD				
West Virginia		USA												
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				
HAGERSTOWN		HAGERSTOWN, W. CH (Wash. Co.)								Watchman Col. Hardware				
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS		21734				
Maryland		Washington		Funkstown				29 E. Cemetery Street						
14. FATHER'S NAME		FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME		LAST				
		Leroy				Frankenberry		Emily		Jane		Chambers		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		16c. INFORMANT		16d. ADDRESS		156 S. Prospect Ave						
No		234-01-7580		Genevieve Clever				Hagerstown, MD 21740						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
IMMEDIATE CAUSE (a) <i>Coronary arrest</i>														
0389 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.														
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Renal failure</i>														
{ DUE TO, OR AS A CONSEQUENCE OF (c) <i>Septicemia</i>														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED								20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
										YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART I OR PART 2)										
		P.M. 19												
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE				
22a. I certify that (I) (this hospital) attended the deceased from <i>10/27/1983</i> to <i>11-1-83</i> , that (I) (we) lost sow the deceased alive on <i>11-1-83</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE <i>Abdul Wahab</i>		DEGREE <i>MD</i>		ATTENDING PHYSICIAN <input type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>11-1-83</i>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS <i>1600 Oak Hill Ave, Hagerstown</i>												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN		COUNTY		STATE				
Burial		Nov. 4, 1983		Green Hill Cemetery		Martinsburg		Berkeley		WV				
24. FUNERAL DIRECTOR NAME <i>Charles M. Brown</i>		ADDRESS 327 W. King POBox 821, Martinsburg, WV								25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <i>NOV 8 1983</i>				
Brown Funeral Home														

100.2.1.5.9 100.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, retumed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR						
Maud			Wolf	Funk		November	28		1983	M						
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS						
Female		White		July 21, 1884		99		MONTHS		YEARS						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY			
Maryland		USA				Washington		Boonsboro			Fahrney-Keedy Memorial Home	homemaker	home			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			14. FATHER'S NAME FIRST			MIDDLE	LAST	
Maryland		Washington		Hagerstown		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		117 E. Franklin St.			Henry			Louisa	Jane	Funk
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		ADDRESS			163 S. Prospect			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
no		216-46-8322		Mrs. Jack H. Beachley Hag., Md. 21740		4140								initial		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		4140		DUE TO, OR AS A CONSEQUENCE OF (b)		cardiac arrest								year		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO, OR AS A CONSEQUENCE OF (c)		atrial fibrillation		congestive heart failure								year		
DUE TO, OR AS A CONSEQUENCE OF (c)		degenerative heart disease												year		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. congestive heart failure · generalized arteriosclerosis																
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?										
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)												
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY	STATE							
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 10/13/1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.		22b. SIGNATURE R. T. Binfold by E. B. Hardy, MD		DEGREE		ATTENDING PHYSICIAN		MEDICAL DIRECTOR <input checked="" type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 11/9/83					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE 12-2-83		23c. NAME OF CEMETERY OR CREMATORIAL Beaver Creek Cem.		23d. LOCATION CITY OR TOWN Washington Co. Maryland		COUNTY	STATE							
24 FUNERAL DIRECTOR NAME Gerald N. Minnich		305 N. Potomac St ADDRESS Hagerstown, Md.		25a. DATE RECEIVED BY REGISTRAR DEC 5 1983		25b. REGISTRAR'S SIGNATURE John J. Conwell										



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										3   266		
REG. NO.												
1. DECEASED NAME (TYPE OR PRINT)			FIRST MILTON MIDDLE E MIDDLE E			LAST GRIMES GRIMES			2a. DATE OF DEATH 11 30 83			2b. HOUR 12 25 PM
3. SEX MALE			4. RACE Caucasian White			5. DATE OF BIRTH MONTH 6 DAY 5 YEAR 05			6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND			7b. CITIZEN OF WHAT COUNTRY? U.S.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED XX			9. BALTIMORE CITY OR COUNTY OF DEATH Washington, MD.			
10. CITY OR TOWN OF DEATH HAGERSTOWN			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Colton Villa Nursing Home			12a. USUAL OCCUPATION Ret. Sec. Guard			12b. KIND OF BUSINESS OR INDUSTRY None			
13a. STATE Maryland			13b. COUNTY Frederick			13c. CITY OR TOWN Thurmont			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS 7439-C Lewistown Road
14. FATHER'S NAME FIRST Shanon MIDDLE Grimes LAST			15. MOTHER'S MAIDEN NAME FIRST Maggie MIDDLE LAST Renner									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 213-01-6288			17. INFORMANT Mrs. Juanita M. Baker			ADDRESS 7439-C Lewistown Rd Thurmont, Md. 21788			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 1991 IMMEDIATE CAUSE (a) Cardiac arrest										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Metastatic carcinoma												
DUE TO, OR AS A CONSEQUENCE OF (c)												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <input type="checkbox"/> (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE G. Baker			22c. DEGREE M.D.			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 11-30-83			
22e. PHYSICIAN'S NAME (TYPE OR PRINT) Abdul Waheed, M.D.			22f. ADDRESS 1600 Oak Hill Ave., Hagerstown, MD									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12-2-1983			23c. NAME OF CEMETERY OR CREMATORIAL WELLER'S CEMETERY			23d. LOCATION CITY OR TOWN Thurmont, Frederick, Maryland			
24. FUNERAL DIRECTOR Robert E. Bailey			615 E. Main Street			25. DATE REC'D. BY REGISTRAR DEC 5 1983			26. REGISTRAR'S SIGNATURE John J. Conroy			
Robert E. Bailey & Son, PA Thurmont, Md. 21788												

Page 4 may be directed, page 3 hours after death

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, please detach for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND 8 3 DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										3 1 2 6 7					
1 - STATE REGISTRAR										REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR			
George Dewey GROVE						11 19 83						12:38 P M			
3. SEX		4 RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS			
Male		White		MONTH 7 DAY 19 YEAR 1898			85			MONTHS	YEARS	HOURS	MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.					
Maryland		U.S.A.					Washington								
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY								
Hagerstown		Ravenwood Lutheran Home		Farmer			Farming								
13a. STATE Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Big Spring			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS RFD-1			21722		
14. FATHER'S NAME FIRST George		MIDDLE M.		LAST Grove			15. MOTHER'S MAIDEN NAME FIRST Martha			MIDDLE Susan		LAST Miller			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
No		217-03-7309		Mrs. Paul Shupp			Clearspring Md.			1000					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)															
4280 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										Acute pulmonary edema					
DUE TO, OR AS A CONSEQUENCE OF (b)										1000					
DUE TO, OR AS A CONSEQUENCE OF (c)										3 AM					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.															
19a. DATE OF OPERATION ASCVD		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE					
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 11-19-83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										19-82 to 11-19-83					
22b. SIGNATURE H. Thompson										DEGREE	22c. DATE SIGNED 4-21-83				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS 1933 1/4 Ave. Hagerstown, Md.													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Nov. 22, 83		23c. NAME OF CEMETERY OR CREMATORIAL St. Pauls			23d. LOCATION CITY OR TOWN Clearspring			COUNTY Wash.	STATE Md.				
24. FUNERAL DIRECTOR Donald E. Thompson Thompson Funeral Home		25a. DATE REC'D. BY REGISTRAR NOV 23 1983		25b. REGISTRAR'S SIGNATURE Debra J. Cawell											



TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be informed.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												31268			
												REG. NO.			
1 - STATE REGISTRAR			I DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a DATE OF DEATH MONTH DAY YEAR			2b HOUR			
			Stephanie Nicole GUESSFORD						November 29, 1983			8:30PM			
3 SEX			4 RACE			5. DATE OF BIRTH MONTH DAY YEAR			6 AGE (IN YEARS LAST BIRTHDAY)			# UNDERS 1 YEAR MONTHS DAYS HOURS MIN			
Female			White			Nov. 29 1983			none			18 57			
7a BIRTHPLACE (COUNTRY)			7b CITIZEN OF WHAT COUNTRY?			MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH			10. CITY OR TOWN OF DEATH			
Hagerstown Washington			US						Washington			Hagerstown			
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			13a STREET ADDRESS			12b KIND OF BUSINESS OR INDUSTRY						
Hagerstown			Washington County Hospital			none			Route # 6 Box 229			MD. 21740			
13a STATE			13b COUNTY			13c CITY OR TOWN			13d INSIDE CITY LIMITS?			14. FATHER'S NAME			
Maryland			Washington			Hagerstown			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			FIRST MIDDLE LAST			
												Jacqueline Ellen Mace			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b SOCIAL SECURITY NO			17 INFORMANT			ADDRESS			18 CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.)			
no			no			no			X8 Roy E. Guessford			PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)			
<b>RESPIRATORY FAILURE</b>														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
7650 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last															
(b) <b>EXTREME IMMATURITY</b>															
(c) <b>23 WEEK GESTATION BIRTH</b>															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED						20a AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
-			-						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			-						
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE			-						
22a I certify that (1) (we) hospital attended the deceased from NOV 29 19 83 to NOV 28 19 83, that (1) (we) last saw the deceased alive on NOV 29 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.															
22b SIGNATURE Robert E. Weiss, M.D.			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 11/29/83						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROBERT E. WEISS, M.D.			22e ADDRESS 1185 MT. AETNA ROAD, HAGERSTOWN, MD.												
23a BURIAL, CREMATION, REMOVAL (SPECIFY) burial Minnich Funeral Home			23b. DATE Dec. 2, 1983			23c NAME OF CEMETERY OR CREMATORIAL Rest Haven Cemetery			23d. LOCATION CITY OR TOWN Hagerstown, Wash., Maryland			23e. DATE REC'D. BY REGISTRAR DEC 2 1983			
24 FUNERAL DIRECTOR NAME E. Wilson Blvd., Hagerstown, Md. 21740			ADDRESS									23f. REGISTRAR'S SIGNATURE John J. Cawley			
DHMH-16 20M (VRA 15, 4) 7/78															



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of cause.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												3 1 2 6 9					
1. FOR STATE REGISTRAR			REG. NO.														
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE			LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR		
HARSHMAN			Leroy Eugene			Harshman Jr.			11 8 83						3 A M		
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS			
MALE			WH.			MONTH 6 DAY 15 YEAR 29			54			MONTHS	DAYS	YRS.	HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.					
Maryland			USA						Washington								
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY								
Hagerstown			Washington County Hospital			truck driver											
13a. STATE Maryland			13b. COUNTY Washington			13c. CITY OR TOWN Boonsboro			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS Route 2, Box 320A			21713		
14. FATHER'S NAME FIRST			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME FIRST			MIDDLE			LAST		
Leroy			E.			Harshman, Sr.			Evelyn						Cole		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS								
Yes 1951-53			217-28-6714			Barbara Harshman, Hagerstown, Md.											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 19 months					
1629 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																	
DUE TO, OR AS A CONSEQUENCE OF (b)																	
DUE TO, OR AS A CONSEQUENCE OF (c)																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
									YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE				
22a. I certify that (I) (this hospital) attended the deceased from 11/8/82 to 11/8/83, that (I) (we) last saw the deceased alive on 11/8/82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE Leroy E. Harshman			4/11/83			DEGREE W.H.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 11/8/83					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE Nov. 10, 1983			23c. NAME OF CEMETERY OR CREMATORIAL Rest Haven Cemetery			23d. LOCATION CITY OR TOWN Hagerstown, Wash., Maryland								
burial																	
24. FUNERAL DIRECTOR NAME 415 E. Wilson Blvd., Hagerstown, Md. 21740									25a. DATE REC'D. BY REGISTRAR NOV 14 1983			REGISTRAR'S SIGNATURE John G. Cough					

1980-1981

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Page 1 and 2 should be retained by the funeral director with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical certifying physician should be notified.

## MEDICAL CERTIFICATION

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND 8 3 3 1 2 7 0  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)	FIRST MARTHA	MIDDLE ELIZABETH	LAST HENSON	2a. DATE OF DEATH 11/ 22/ 83	MONTH DAY YEAR	2b. HOUR M
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH 3/ DAY 27/ YEAR 16	6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Washington	MD.		
10. CITY OR TOWN OF DEATH Hagerstown, MD	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	12b. KIND OF BUSINESS OR INDUSTRY None	21740		
13. PREVIOUS RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) IN STATE Maryland	13a. COUNTY Washington	13b. CITY OR TOWN Hagerstown	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 444 Mitchell Avenue		
14. FATHER'S NAME FIRST Oliver	MIDDLE	LAST Crampton	15. MOTHER'S MAIDEN NAME FIRST Reba	MIDDLE E.	LAST Swain	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) NO	16b. SOCIAL SECURITY NO. 219-07-9603	17. INFORMANT Charlotte Tracey, Hagerstown, Md.	ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cachexia - Uremia</u> 1809 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Squamous Carcinoma</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>of Cervix Stage IV</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:						
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>11/21</u> , 19 <u>83</u> , to <u>11/22</u> , 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>11/22</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <u>F. D. Dove</u>	22c. DEGREE <u>M.D.</u>	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22d. DATE SIGNED 11/23/83			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) F. D. Dove, Jr., M. D.	22e. ADDRESS 363 S. Cleveland Avenue Hagerstown, MD 21740					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial	23b. DATE Nov. 26, 1983	23c. NAME OF CEMETERY OR CREMATORIAL Cedar Lawn Mem. Park	23d. LOCATION CITY OR TOWN Hagerstown, Wash., Maryland	23e. COUNTY	23f. STATE	
24. FUNERAL DIRECTOR MINNICH FUNERAL HOME NAME 415 E. Wilson Blvd., Hagerstown, Md. 21740	25a. DATE REC'D. BY REGISTRAR NOV 28 1983	25b. REGISTRAR'S SIGNATURE <u>John J. Minnich</u>				

inward - inward

inward - inward



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND 8 3 DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 3 1 2 7 1														
REG. NO.														
1 - STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST Betty			MIDDLE Lee			LAST Hesson		
2a. DATE OF DEATH			MONTH 11-26-83			DAY			YEAR			2b. HOUR M		
3. SEX Female			4. RACE White			5. DATE OF BIRTH MONTH DAY YEAR Sept. 22 1929			6. AGE (IN YEARS LAST BIRTHDAY) 54 YRS.			IF UNDER 1 YEAR MONTHS DAYS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Washington			IF UNDER 24 HRS HOURS MIN.		
10. CITY OR TOWN OF DEATH Hagerstown			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secretary			12b. KIND OF BUSINESS OR INDUSTRY Physician					
13a. STATE Maryland			13b. COUNTY Washington			13c. CITY OR TOWN Hagerstown			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 103 Belview Avenue		
14. FATHER'S NAME FIRST Lawrence			MIDDLE Lewis			LAST Toms			15. MOTHER'S MAIDEN NAME FIRST Anna			MIDDLE LAST Dorty		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 215-26-2023			17. INFORMANT Erin G. Hesson Same as #13			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>1749</u> <u>Cancer of breast with metastasis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) <u>metastasis to stomach, spine, bone and</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>open</u> <u>5 years</u>														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>March 29, 1982</u> to <u>Mar 26 1983</u> , that (I) (was last saw the deceased alive on <u>Mar 26 1983</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.														
22b. SIGNATURE <u>Richard E. Smith, M.D.</u>			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 11-28-83					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Richard E. Smith, M.D.			22e. ADDRESS 1708 Oak Hill Ave., Hagerstown, Md. 21740											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 11-29-83			23c. NAME OF CEMETERY OR CREMATORIAL RestHaven Cemetery			23d. LOCATION CITY OR TOWN Hagerstown			COUNTY STATE Wash. Md.		
24. FUNERAL DIRECTOR NAME Gerald N. Minnich			ADDRESS 305 N. Potomac St. Hagerstown, Maryland			25a. DATE REC'D. BY REGISTRAR DEC 07 1983			25b. REGISTRAR'S SIGNATURE <u>John J. Cahill</u>					



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

Hollenshead

REG. NO.

1 - STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR							
Sylvia J. Hollenshead						11	29	83		4:28 P.M.							
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS							
FEMALE		WHITE		MAY 12 1931		63		MONTHS DAYS		HOURS MIN.							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH		10 CITY OR TOWN OF DEATH									
PA		USA				WASHINGTON CO.		HAGERSTOWN									
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		13a. CITY OR TOWN 13b. COUNTY		13d. INSIDE CITY LIMITS?				13e. STREET ADDRESS / ZIP CODE					
WASH. CO. HOSPITAL		TEACHER		EDUCATION		ST THOMAS		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		PA		6316 L.W.W. Box 245 17052					
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ALBERT DESHONG		GOLDE KLINE		NO		186-38-6308		MRS TED HORNER 141 SALEM CH. RD. MECHANICSBURG PA		5603				17053			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		(b)		DUE TO, OR AS A CONSEQUENCE OF PARALYTIC ILLNESS		(c)		DUE TO, OR AS A CONSEQUENCE OF END STAGE RENAL DISEASE									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) CHOLERITHIASIS																	
19a. DATE OF OPERATION 11. 26. 83		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED CHOLERITHIASIS - CYSTITS				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (# EITHER NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM ETC.)				21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE					
22a. I certify that (I) (this hospital) attended the deceased from 1877, 19, to 11. 29, 19, that (I) (we) last saw the deceased alive on 11. 28, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE Ottie R. Rosa		22c. DEGREE N.D.				22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22e. DATE SIGNED 11. 29. 83									
22d. PHYSICIAN'S NAME (TYPE OR PRINT) OTTO R. ROSA		22e. ADDRESS 100 LONG MEADOW DRVR 17052 NY.															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 10/3/83		23c. NAME OF CEMETERY OR CREMATORIAL ST THOMAS CEMETERY		23d. LOCATION CITY OR TOWN ST THOMAS COUNTY PA STATE											
24. FUNERAL DIRECTOR NAME R.G. SELLERS F.H.		ADDRESS 297 PHILA. AVE CHAMPS PA 17201		25a. DATE REC'D. BY REGISTRAR DEC 6 1983		25b. REGISTRAR'S SIGNATURE John J. Canfield											

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death.

With the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event,  
inform the physician or attending physician.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified and given

STATE OF MARYLAND 8 3 DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												
REG. NO. 11 / 7 / 83												
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR 9:30 AM			
Hazel T. Hoyer						11 / 7 / 83						
3. SEX Fem.		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
				Mar. 21, 1922			61 YRS.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penna.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Washington Co., MD.					
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT A SURGEON, GIVE STREET ADDRESS) Washington Co. Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Nurse			12b. KIND OF BUSINESS OR INDUSTRY Nursing					
13a. STATE Md.		13b. COUNTY Washington		13c. CITY OR TOWN St. James			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS St. James School 21781		
14. FATHER'S NAME FIRST Russell MIDDLE Smith LAST				15. MOTHER'S MAIDEN NAME Florence						16. ADDRESS Rotz		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 216-30-2802		17. INFORMANT St. James School						Edgar Hoyer, Jr. St. James, Md. 21781		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>cardiogenic shock</u> APPROXIMATE INTERVAL 41000 BETWEEN ONSET AND DEATH 2 hours DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, lost. (b) <u>acute myocardial infarction</u> 2 days (c) <u></u>												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <u>Diabetes mellitus</u>												
19a. MEDICAL CERTIFICATION DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from 19-75 to November 3, 1983, that (I) (we) last saw the deceased alive on November 3, 1983, and that in (my) <input type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input type="checkbox"/> (we) <input type="checkbox"/> (did not) view the body after death.												
22b. SIGNATURE <u>Edson B. Moody</u>		22c. DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 11/7/83					
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Edson B. Moody</u>		22f. ADDRESS RT #3 Box 163 Hagerstown										
23a. BURIAL, CREMATION, REMOVAL <u>Burial</u>		23b. DATE 11/10/83		23c. NAME OF CEMETERY OR CREMATORIAL 17236			23d. LOCATION CITY OR TOWN <u>St. Thomas Cem.</u> COUNTY <u>St. Thomas Twp. Franklin Pa.</u> STATE					
24. FUNERAL DIRECTOR <u>T. Mr. Benning</u>		25a. DATE REC'D. BY REGISTRAR <u>10/10/83</u>		25b. REGISTRAR'S SIGNATURE <u>J. M. Coughlin</u>								
BP _____												



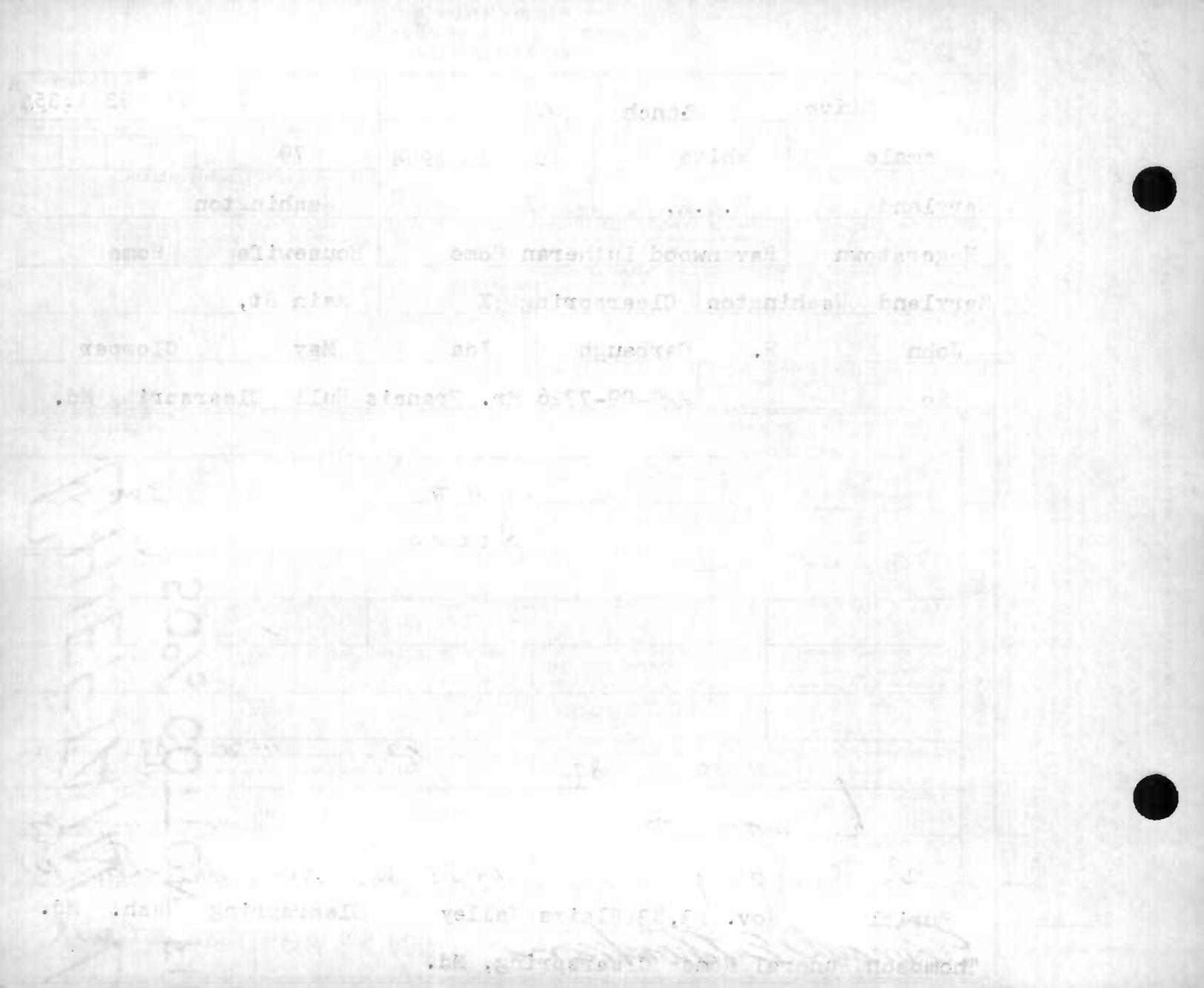
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND 8 3 3 1 2 7 4 DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
REG. NO.											
1. DECEASED NAME (TYPE OR PRINT)			MIDDLE			LAST			2a. DATE OF DEATH		
Olive			Branch			HULL			11 21 83		
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)		
Female			White			MONTH 10 DAY 13 YEAR 1904			79 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH		
Maryland			U.S.A.						Washington MD.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Hagerstown			Ravenwood Lutheran Home			Housewife			Home		
13a. STATE			13b. COUNTY			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS		
Maryland			Washington			Clearspring			Main St., 21722		
14. FATHER'S NAME			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME		
John			H.			Carbaugh			Ida May Clopper		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS		
No			220-09-7726			Mr. Francis Hull			Clearspring Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4292 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
DUE TO, OR AS A CONSEQUENCE OF (b) L. H. T DUE TO, OR AS A CONSEQUENCE OF (c) AICVO APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 weeks yrs											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 19 82 to 11-20 19 82, that (I) (we) last saw the deceased olive on 11-20 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.											
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS						10-20-82		
Burial			Nov. 23, 83			Blairs Valley			1933 1/2 Ave. Hagerstown, Md.		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN		
Burial			Nov. 23, 83			Blairs Valley			Clearspring Wash. Md.		
24. FUNERAL DIRECTOR NAME			25. DATE RECEIVED BY REGISTRAR								
Donald E. Thompson									NOV 23 1983		
Thompson Funeral Home			Clearspring, Md.								



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												3 1 2 7 5			
1. FOR STATE REGISTRAR			REG. NO.												
1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR				
Emma Pearl Husa				Husa	10	11	1910	11	-23-83		M				
3. SEX Female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Tilghmanton, Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Washington			MD.					
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY								
13a. STATE Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Sharpsburg		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Route 1, Box 230		21782					
14. FATHER'S NAME Hyman		15. MOTHER'S MAIDEN NAME Moats		16. SOCIAL SECURITY NO. 363-20-3827A		17. INFORMANT Walfred H. Husa, Sharpsburg, Md.		ADDRESS Kitzmiller							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4140		DUE TO, OR AS A CONSEQUENCE OF - (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO, OR AS A CONSEQUENCE OF (c)		Congestive Heart Failure Cerebrovascular heart disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o)															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE Signature		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 11-24-83					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) burial		22e. ADDRESS													
23a. BURIAL, CREMATION, REMOVAL SPECIAL		23b. DATE Nov. 28, 1983		23c. NAME OF CEMETERY OR CREMATORIAL Greenlawn Memorial Park		23d. LOCATION CITY OR TOWN Williamsport, Wash., Md.		COUNTY		STATE					
24. FUNERAL DIRECTOR NAME 415 E. Wilson Blvd., Hagerstown, Md. 21740		ADDRESS		25a. DATE REC'D. BY REGISTRAR NOV 28 1983		25b. REGISTRAR'S SIGNATURE John J. Canfield									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please

retoned by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Page 1 and 2 should be filled within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner will be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												31276											
											REG. NO.												
1 - FOR STATE REGISTRAR																							
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR									
Rhoda		Grace		Kallaway		Kallaway			November 11, 1983			8:30 A.M.											
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR			8. IF UNDER 24 HRS											
Female		White		Jan. 24, 1915		68			MONTHS			DAYS											
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.											
Penns.		U.S.A.				Washington County,																	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY																
Sharpsburg		Route 2, Box 352,		Merchant			Retail sales																
13a. STATE Maryland												13b. COUNTY Frederick			13c. CITY OR TOWN Frederick			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 118 North Court Street, 21701		
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST			MIDDLE			LAST											
Miles				Altimus		Matilda						Watson											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT			ADDRESS																
No		None		214010-3581			Mrs. Susan Sexton,			Route 2, Box 352			Sharpsburg, Md. 21782										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>1749</u>												<u>CARCINOMA OF THE BREAST c pleural metast.</u>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																							
DUE TO, OR AS A CONSEQUENCE OF (b)																							
DUE TO, OR AS A CONSEQUENCE OF (c)																							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																							
Congestive heart failure 2° to recent myocardial infarction																							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?															
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE												
22a. I certify that (I) (this hospital) attended the deceased from <u>February 19 80</u> to <u>November 19 83</u> , that (I) (we) last saw the deceased alive on <u>November 19 83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (do) (did not) view the body after death.																							
22b. SIGNATURE <u>George I. Smith Jr. M.D.</u>												DEGREE			22c. DATE SIGNED 11 Nov. 83								
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			ATTENDING PHYSICIAN			MEDICAL DIRECTOR			STAFF PHYSICIAN												
Dr. George I. Smith, Jr., M.D.		804 Toll House Ave., Frederick, Md. 21701			<input type="checkbox"/>			<input checked="" type="checkbox"/>			<input type="checkbox"/>												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORI		23d. LOCATION CITY OR TOWN			23e. COUNTY			23f. STATE											
Burial		Nov 14, 1983		Mt. Olivet Cemetery		Frederick, Frederick, Md.																	
24. FUNERAL DIRECTOR <u>Richard C. Basford</u> Smith, Keeney and Basford Funeral Home 106 East Church St., Frederick, Md. 21701												25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE <u>John J. Cawley</u>								
NOV 17 1983																							

kind of a day, and I am not able to do much work.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, an other traumatic event, the medical certifier must be present.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										31271						
1. FOR STATE REGISTRAR			REG. NO.													
1. DECEASED NAME (TYPE OR PRINT)	FIRST		MIDDLE		LAST			2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR			
Harvey Russell KERSHNER								November 26, 1983					4 P.M.			
3. SEX male	4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR May 29, 1901			6. AGE IN YEARS (LAST BIRTHDAY) 82 YRS.		7. IF UNDER 1 YEAR MONTHS		8. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.						
7. BIRTHPLACE Maryland	8. CITIZEN OF WHAT COUNTRY? U.S.A.		9. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Washington		10. CITY OR TOWN OF DEATH Funkstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 13 East Baltimore Street			12a. USUAL OCCUPATION Highway Postal Service		12b. KIND OF BUSINESS OR INDUSTRY U. S.	
13a. STATE Maryland	13b. COUNTY Washington		13c. CITY OR TOWN Funkstown			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 13 East Baltimore Street		21734						
14. FATHER'S NAME William	15. MOTHER'S MAIDEN NAME Kershner		16. SOCIAL SECURITY NO. 213-03-0628			17. INFORMANT Mrs. Emma K. Kershner, Funkstown, Md.		ADDRESS								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4140 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last	18. DUE TO, OR AS A CONSEQUENCE OF (b) <i>Arteriosclerotic Heart Disease</i>			18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes.												
19. MEDICAL CERTIFICATION Asthma	19. DUE TO, OR AS A CONSEQUENCE OF (c)															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE					
22a. I certify that (I) (this hospital) attended the deceased from <i>4-24-78</i> , 19 <i>83</i> , to <i>11-14-83</i> , 19 <i>83</i> , that (I) <input type="checkbox"/> last saw the deceased alive on <i>11-14-83</i> , 19 <i>83</i> , and that in (my) <input type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. <i>I did not</i> view the body after death.																
22b. SIGNATURE <i>John Spencer</i>												22c. DEGREE				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Charles L. Spencer, M.D.</i>												22e. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				
22f. ADDRESS <i>1198 Kirby Ave Hagerstown, Md.</i>												22g. DATE SIGNED <i>11-28-83</i>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE burial Nov. 29, 1983		23c. NAME OF CEMETERY OR CREMATORIAL Rest Haven Cemetery			23d. LOCATION CITY OR TOWN Hagerstown, Wash., Maryland		23e. COUNTY		23f. STATE					
24. FUNERAL DIRECTOR MINNICH FUNERAL HOME 415 East Wilson Blvd., Hagerstown, Maryland		25a. DATE REC'D. BY REGISTRAR ADDRESS 415 East Wilson Blvd., Hagerstown, Maryland			25b. REGISTRAR'S SIGNATURE <i>John L. Spencer</i>											

RECEIVED  
1970-03-10 09:30 AM  
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RECEIVED  
1970-03-10 09:30 AM  
FBI - BOSTON

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND 83 31278 DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
REG. NO.										
1 - FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR							
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE			LAST		2b. HOUR		
Rosa Lee			KING			November 19, 1983		4:00A M		
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			
Female		White		October 19, 1943			44 YRS.			
7a. BIRTHPLACE (COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			
West Virginia		U. S. A.					Washington MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)							12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Keedysville		P. O. Box 325							Housewife	
13a. STATE Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Keedysville			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS P. O. Box 325 21756	
14. FATHER'S NAME FIRST		MIDDLE		15. MOTHER'S MAIDEN NAME FIRST			MIDDLE		16b. KIND OF BUSINESS OR INDUSTRY Own Home	
Raymond		Radliff		Virginia			Brady			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS			
No		236- 68-1980		Mr. James W. King,			P. O. Box 325 Keedysville, Md. 21756			
18. CAUSE OF DEATH (Enter only one cause per line for 18, 1b and 1c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1820 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										2 months
1820 DUE TO, OR AS A CONSEQUENCE OF (b) Stage IV endometrial carcinoma										
DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)			21f. LOCATION STREET			CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 11/18/83 to 11/18/83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										22c. DATE SIGNED 11/21/83
22b. SIGNATURE R.L. Kugler		22c. DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) R.L. Kugler MD		22e. ADDRESS 100 Geeting Lane Keedysville, Md.								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal- Burial		23b. DATE 11-21-83		23c. NAME OF CEMETERY OR CREMATORIUM Long Shoal Cemetery			23d. LOCATION CITY OR TOWN Gilmer		23e. COUNTY Gilmer Co., W. Va. STATE	
24. FUNERAL DIRECTOR NAME John H. Bast, Jr. ADDRESS Boonsboro, Md. 21713					25a. DATE REC'D. BY REGISTRAR NOV 28 1983			25b. REGISTRAR'S SIGNATURE		



O HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 may be

dejoned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										83	31279			
										REG. NO.				
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR		
Homer M. Litton						11 23 83						350 PM		
3. SEX			4. RACE			5. DATE OF BIRTH			MONTH	DAY	YEAR			
Male			White			05 - 09 - 1915								
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		
Plum Run, Pa.			United States			<input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			68			MONTHS DAYS		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Hagerstown			Washington Co. Hospital			Retired								
13a. STATE Pennsylvania			13b. COUNTY Fulton			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS Star Rt #1 Box 52A			99999		
14. FATHER'S NAME OSCAR			15. MOTHER'S MAIDEN NAME Mary									Hewett		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. 192-30-0722			17. INFORMANT Ida Litton			ADDRESS					
NO														
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART 1. DEATH WAS CAUSED BY: 1679 IMMEDIATE CAUSE (a) <i>cardiovascular disease</i>													APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>concremation of the carcass</i>														
DUE TO, OR AS A CONSEQUENCE OF (c)														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a). <i>Renal insufficiency and failure</i>														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
						<input type="checkbox"/> YES <input type="checkbox"/> NO			<input type="checkbox"/> YES <input type="checkbox"/> NO					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from 10-14, 19 83, to 11-23 19 83, that (I) (we) last saw the deceased alive on 11-23 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.														
22b. SIGNATURE <i>Roger Cornelius</i>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 11-23-83					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE 11/26/83			23c. NAME OF CEMETERY OR CREMATORIUM Damascus Christian Cem			23d. LOCATION CITY OR TOWN Big Cove Tannery Fulton Pa			COUNTY STATE		
24. FUNERAL DIRECTOR NAME Rodger Cornelius			ADDRESS 322 N. 2nd St. McConnellsburg Pa			25a. DATE REC'D. BY REGISTRAR NOV 28 1983			25b. REGISTRAR'S SIGNATURE <i>John J. Connelly</i>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page \_\_\_\_\_ retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND 83 31280 DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. DECEASED NAME (TYPE OR PRINT)					REG. NO.				
<i>Charles William Madison</i>					Nov. 29 1983				
1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH		MONTH	DAY	YEAR
<i>Charles William Madison</i>					Nov. 29 1983				
3. SEX		4. RACE		5. DATE OF BIRTH	2b. HOUR				
Male		White		MONTH DAY YEAR March 20, 1925	9:30 A.M.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.				
Maryland		U.S.A.		MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		9. BALTIMORE CITY OR COUNTY OF DEATH					
Hagerstown		Washington County Hospital		Washington County					
12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
Maryland		Washington		Hagerstown		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		653 Pin Oak Road 21740	
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME		16. ADDRESS		
		Charles	Samuel	Madison	Katherine Jeanette Scott		653 Pin Oak Road Hagerstown, Md.		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
Yes		WWII		219-12-1144		Gloria D. Madison 2 hours			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiogenic Shock</i>									
4254 DUE TO, OR AS A CONSEQUENCE OF (b) <i>Congestive Cardiomyopathy</i> 2 years.									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Arteriosclerotic Heart disease</i> 6 years.									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <i>Diabetes mellitus.</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
YES <input type="checkbox"/> NO <input type="checkbox"/>						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 19 20, to 11-29 19 83, that (I) (we) last saw the deceased alive on 11-29 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 11-29-83			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		<i>Charles P. Spencer</i> 1198 Kelly Ave Hagerstown Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN			
Burial		12-183		Rose Hill Cemetery		Hagerstown Washington, Md.			
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
A. K. Coffman Funeral Home, Inc., Hagerstown, Md.				DEC 2 1983		<i>John J. Coffman</i>			



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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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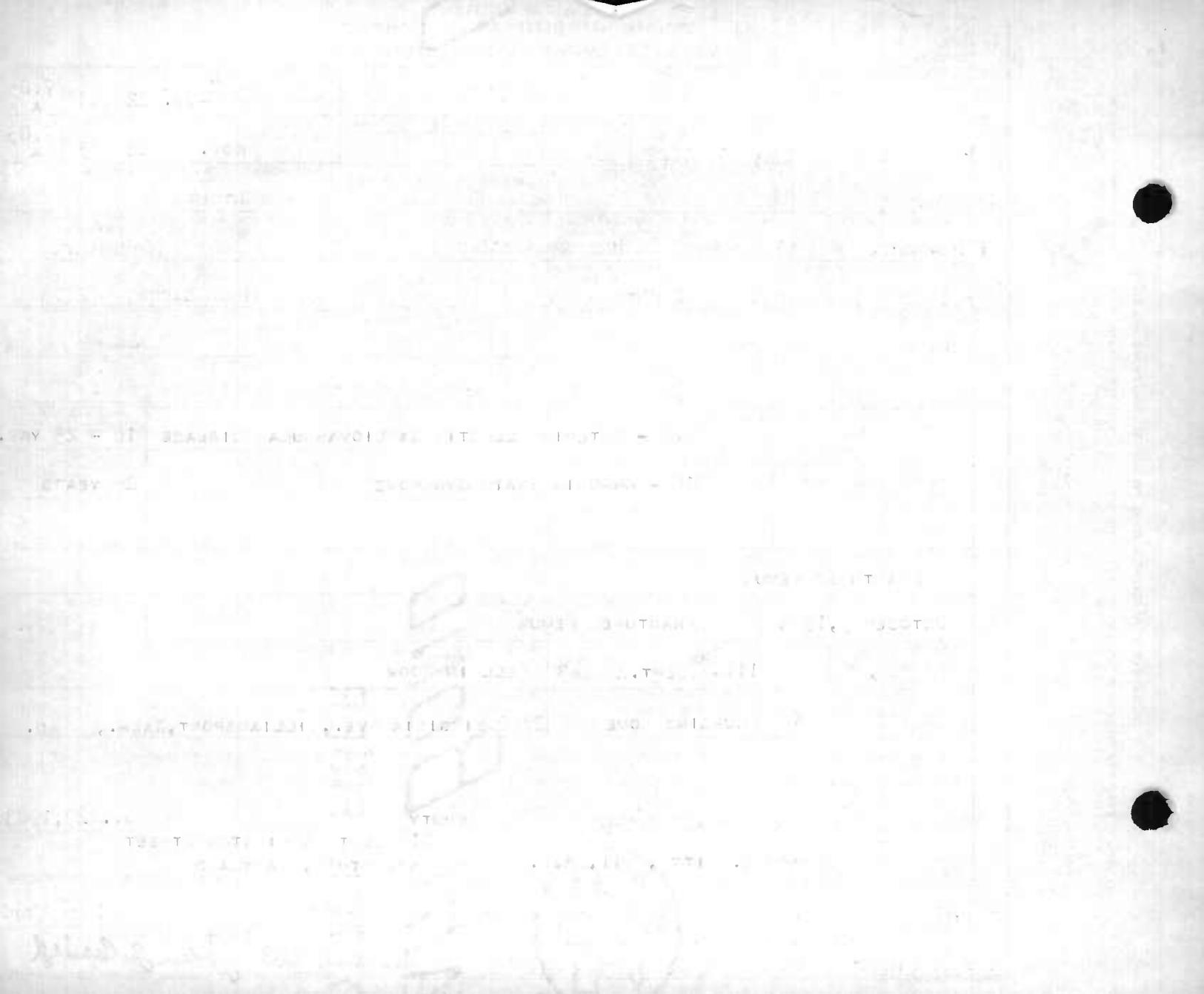
## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												83	31281		
												REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2d. DATE OF DEATH			MONTH DAY YEAR			2b. HOUR			
Walter			Hampton			Martin Jr.			11-14-83			10 25 AM			
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS			
male		white		MONTH November DAY 6, 1922			61			MONTHS		DAYS HOURS MIN.			
7a. BIRTHPLACE (COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8			MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH					
West Virginia		USA								Washington					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Hagerstown		Washington County Hospital										machine repair		MD.	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS					
Maryland		Washington		Hagerstown						Route 1, Box 379					
14. FATHER'S NAME		FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME						MIDDLE		LAST			
		Walter H. Martin, Sr.		Muri						Susan		Brown			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT						ADDRESS					
Yes		W.W.II		235-30-0337						Mrs. Anna R. Martin, Hagerstown, Md.					
18. CAUSE OF DEATH (Enter only one cause of death, if applicable, for Part 1 or Part 2.) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
5715 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any.															
DUE TO, OR AS A CONSEQUENCE OF (b)															
DUE TO, OR AS A CONSEQUENCE OF (c)															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
												YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)										
					P.M. 19										
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE			
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>															
22a. I certify that (1) this hospital attended the deceased from 80-85 19 62 to 8-10-85 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.												22c. DATE SIGNED 11-14-83			
22b. SIGNATURE		DEGREE										ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			
E. R. Landrab															
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			22f. ADDRESS										
E. R. Landrab		582			John Cleveland, Hagerstown, Wash., Maryland										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL CITY OR TOWN			23d. LOCATION CITY OR TOWN		23e. COUNTY		STATE			
burial		Nov. 17, 1983			Cedar Lawn Mem. Park			Hagerstown, Wash.		Maryland		MD.			
24. FUNERAL DIRECTOR NAME		MINNICH FUNERAL HOME ADDRESS			25a. DATE RECEIVED BY REGISTRAR			25b. DATE OF TRANSMISSION		25c. DATE RECEIVED BY REGISTRAR					
John G. Landrab		415 E. Wilson Blvd., Hagerstown, Md. 21740			NOV 17 1983										

kindred 10 11

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DEATH IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201, PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												3   2   8   2			
												REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)			FIRST Irving			MIDDLE NMN			LAST McCLAVE			2a. DATE KNOWN OF ESTI- DEATH MATED	MONTH Nov. 22 1983	DAY YEAR	2b. HOUR 7:05 A M
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR. MONTHS DAYS	8. IF UNDER 24 HRS. HOURS MIN.							2c. DATE PRONOUNCED DEAD	MONTH Nov. 22 1983	DAY YEAR	2d. HOUR 7:05 A M
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED WIDOWED			9. MARRIED NEVER MARRIED DIVORCED			9. BALTIMORE CITY OR COUNTY OF DEATH				
New Jersey		USA									Washington				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
Williamsport			Homewood Retirement Center						sales			furniture			
13a. STATE Maryland			13b. COUNTY Washington		13c. CITY OR TOWN Williamsport		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 136 N. Artizan Street		21795				
14. FATHER'S NAME FIRST William			MIDDLE Henry		LAST McClave		15. MOTHER'S MAIDEN NAME FIRST Hannah		MIDDLE Moore		Sproston Moore				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS						
No			335-38-9491			Norman Holzapfel, Hagerstown, Md.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). 4292 Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. { DUE TO, OR AS A CONSEQUENCE OF #429 - ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 - 25 YRS			
(b). #310 - CHRONIC BRAIN SYNDROME { DUE TO, OR AS A CONSEQUENCE OF (c). 25 YEARS															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (b). FRACTURED FEMUR															
19a. DATE OF OPERATION OCTOBER 7, 1983			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED FRACTURED FEMUR						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY 11:45 P.M. SEPT. 28 1983			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) FELL IN ROOM									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) NURSING HOME			21f. LOCATION STREET 2750 VIRGINIA AVE., WILLIAMSPORT, WASH., MD.			CITY OR TOWN COUNTY STATE						
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE Edward W. Ditto			TITLE (SPECIFY) M.D. DEPUTY						DATE SIGNED Nov. 23, 1983						
EXAMINER'S NAME (TYPE OR PRINT)			MEDICAL EXAMINER 217 WEST WASHINGTON STREET												
EDWARD W. DITTO, III, M.D.			ADDRESS HAGERSTOWN, MARYLAND												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial			23b. DATE Nov. 25, 1983			23c. NAME OF CEMETERY OR CREMATORIUM Greenwood Cemetery			23d. LOCATION CITY OR TOWN Brooklyn,			COUNTY STATE New York			
24. FUNERAL DIRECTOR NAME MINNICH FUNERAL HOME 415 E. Wilson Blvd. Hagerstown, Md. 21740			25a. DATE REC'D. BY REGISTRAR NOV 28 1983						25b. REGISTRAR'S SIGNATURE John J. Canfield						

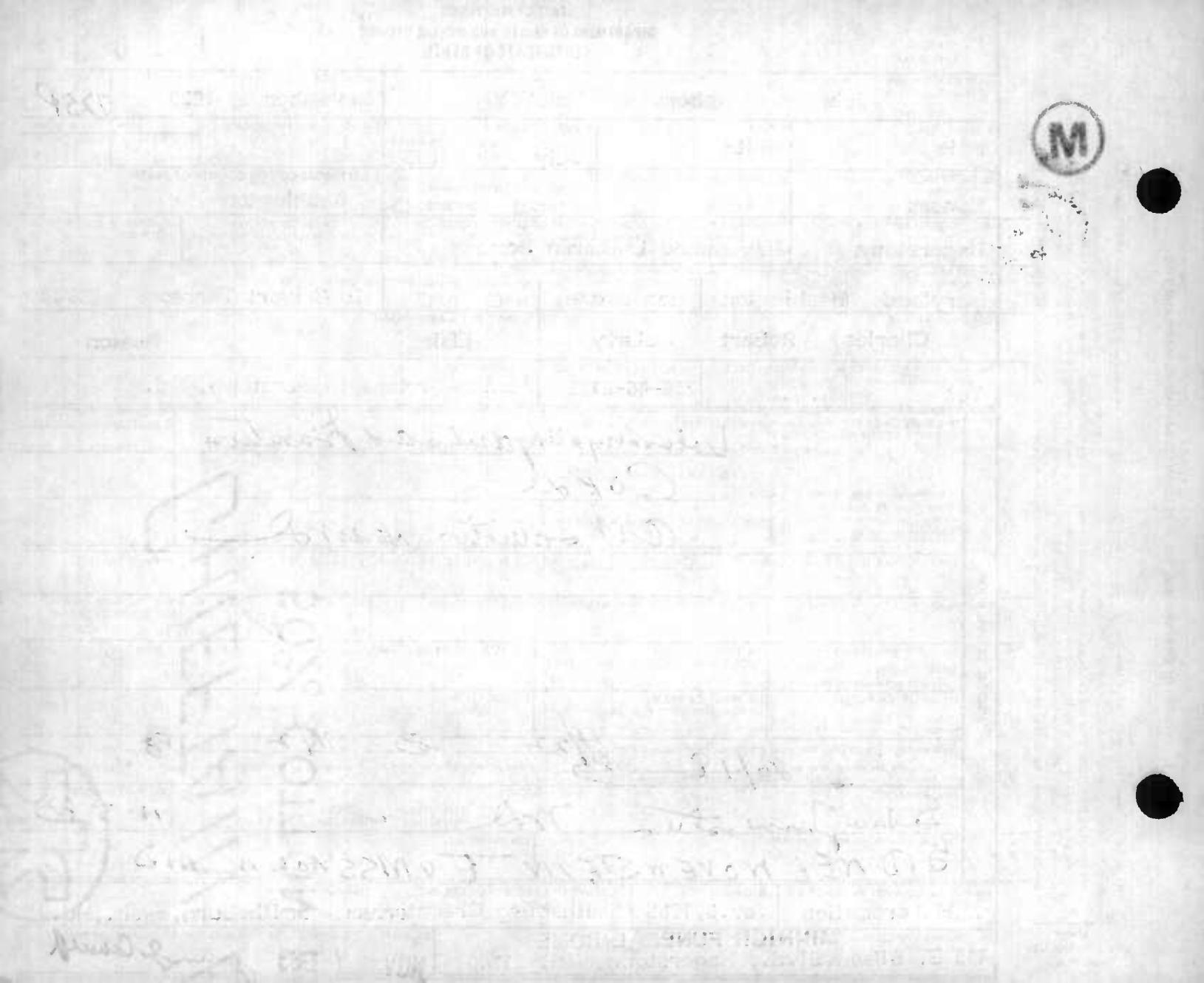


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of the same.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												3	3	1	2	8	3				
												REG. NO. 31283									
1 - FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST John			MIDDLE Robert			LAST McLAVY			2a. DATE OF DEATH November 2, 1983			2b. HOUR 125P M			
3. SEX male			4. RACE white			5. DATE OF BIRTH MONTH July			DAY 29			YEAR 1892			6. AGE (IN YEARS LAST BIRTHDAY) 91 YRS.			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Kansas			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.												
10. CITY OR TOWN OF DEATH Hagerstown			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Ravenwood Lutheran Home			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY												
13a. STATE Maryland			13b. COUNTY Washington			13c. CITY OR TOWN Hagerstown			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 10 Calvert Terrace 21740									
14. FATHER'S NAME Charles Robert McLavy						15. MOTHER'S MAIDEN NAME Elsie															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) W.W.I			17. INFORMANT Jeanne Graham, Hagerstown, Md.			ADDRESS												
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4140 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Ob. de -</i>																					
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Onset heart</i>																					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																					
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>												
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE						
22a. I certify that (I) (this hospital) attended the deceased from <i>11/22</i> , 19 <i>83</i> to <i>11/2</i> , 19 <i>83</i> , that (I) (we) last saw the deceased alive on <i>10/12</i> , 19 <i>83</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																					
22b. SIGNATURE <i>Sidney Novak</i>			22c. DEGREE <i>MD</i>			22d. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. DATE SIGNED <i>11-3-83</i>												
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <i>SIDNEY NOVAK</i>			22f. ADDRESS <i>Hagerstown, MD</i>																		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) cremation			23b. DATE Nov. 3, 1983			23c. NAME OF CEMETERY OR CREMATORIUM Smithsburg Crematorium			23d. LOCATION CITY OR TOWN			COUNTY			STATE						
24. FUNERAL DIRECTOR MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740						25a. DATE REC'D. BY REGISTRAR NOV 7 1983			25b. REGISTRAR'S SIGNATURE <i>John J. Conroy</i>												



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										3 1 2 8 4							
										REG. NO.							
1. FOR STATE REGISTRAR			I. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR		
			Albert Earl Mentzer						Nov 21 1983						5:45 A.M.		
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF OVER 24 HRS			
Male			White			MONTH Feb. DAY 15 YEAR 1908			75			MONTHS	DAYS	HOURS	MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.					
Penns.			U.S.A.			MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			Washington County			State of Maryland					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY								
Hagerstown			Washington County Hospital						Public Info. Officer								
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS					
Maryland			Washington			Hagerstown			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			600 Pin Oak Road			21740		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME														
FIRST Albert			MIDDLE S.			LAST Mentzer			FIRST Helen			MIDDLE B.			LAST Motz		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
no			188-03-1491			Mrs. A. Earl Mentzer			9 mo.								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										Adenocarcinoma of Stomach							
1519 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																	
(b)																	
(c)																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?								
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)											
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE				
22a. I certify that (I) (this hospital) attended the deceased from 9-15 1982, to 11-21 1983, that (I) (we) last saw the deceased alive on 11-20 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (do not) view the body after death.																	
22b. SIGNATURE John C. Spencer										DEGREE MD	ATTENDING PHYSICIAN <input checked="" type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 11-21-83			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John C. Spencer			22e. ADDRESS 1198 Kelly Ave Hagerstown Md.														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 11/23/1983			23c. NAME OF CEMETERY OR CREMATORIUM Burns Hill Cemetery			23d. LOCATION TOWNSHIP Waynesboro			COUNTY Franklin		STATE Pa.			
24. FUNERAL DIRECTOR NAME Terry Goss			ADDRESS Waynesboro, Penna.			25a. DATE REC'D. BY REGISTRAR NOV 28 1983			25b. REGISTRAR'S SIGNATURE John J. Conroy								



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury or other traumatic event, the medical certificate must be completed.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 3 3 1 2 8 5							
										REG. NO.							
1 - FOR STATE REGISTRAR			2a DATE OF DEATH MONTH DAY YEAR							2b HOUR							
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			November 18, 1983							10:40A M				
Lillian Margaret MILLER																	
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS.			
Female			White			June 19, 1894			89			MONTHS DAYS		HOURS MIN			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8			9 BALTIMORE CITY OR COUNTY OF DEATH			MD.					
Boonsboro, Md.			U. S. A.			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			Washington								
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR ADULTS WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY								
Hagerstown			Washington County Hospital			Housewife			Own Home								
SPECIAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)																	
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS					
Maryland			Washington			Boonsboro						334 N. Main St. 21713					
14. FATHER'S NAME			15. MOTHER'S M AIDEN NAME			16. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS					
William			Sue			214-10-5985D			J. William Miller,			5011 Mayflower Rd. Norfolk, Va. 23508					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
No												3 months					
17. IMMEDIATE CAUSE (a)			18. DUE TO, OR AS A CONSEQUENCE OF (b)			19. DUE TO, OR AS A CONSEQUENCE OF (c)											
1749			Metastatic adenos carcinoma of left breast to skeleton and brain														
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
20a. DATE OF OPERATION			20b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20c. AUTOPSY?			20d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?								
						YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 11-17-1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										22c. DATE SIGNED 11-18-83							
22b. SIGNATURE J. S. Condari										DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS			23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN		
JOSPEH S. CONDARI			Boonsboro 21713			Burial			11-21-83			Boonsboro Cemetery			Boonsboro, Wash Co., Md. STATE		
24. FUNERAL DIRECTOR NAME John H. Bast, Jr. Boonsboro, Md. 21713										25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE				
										NOV 22 1983			John H. Bast, Jr.				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical certifier must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										3 1 2 8 6					
										REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)			FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
<i>Joseph W. Mills</i>									NOVEMBER 10, 1983					100/PM	
3. SEX			4. RACE		5. DATE OF BIRTH		MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS		
Male			White		Dec. 10, 1900				82		YRS.		MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		Washington MD.				
Maryland			U.S.A.						Washington						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY								
Hagerstown			Washington County		Foreman		Motel								
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS						
Maryland			Washington		Hagerstown		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		RFD-6 Box 117 21740						
14. FATHER'S NAME FIRST			MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST				
Joseph					Mills		Barbara		Ellen		Carty				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS								
No			214-07-6871		Mr. Charles Mills Sharpsburg Md.		RFD-1 Box 302A								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
<i>1629</i> PULMONARY CHCINOMA, SQUAMOUS CELL										17 MONTHS					
DUE TO, OR AS A CONSEQUENCE OF (b)															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, lost.															
DUE TO, OR AS A CONSEQUENCE OF (c)															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)			PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)		PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)		PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)		PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)		PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)		PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)		
19a. DATE OF OPERATION <i>None</i>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 21)		YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE				
22a. I certify that (I) (this hospital) attended the deceased from NOVEMBER 1 1983 to NOVEMBER 10 1983, that (I) (we) last saw the deceased alive on NOVEMBER 10 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE <i>Barry M. Carty</i>										DEGREE		22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Barry M. Carty</i>										ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial										23b. DATE Nov. 14, 83		23c. NAME OF CEMETERY OR CREMATORIAL Cedar Lawn		23d. LOCATION CITY OR TOWN Hag. Wash. Md.	
24. FUNERAL DIRECTOR Donald E. Thompson Thompson Funeral Home										25a. DATE REC'D. BY REGISTRAR NOV 16 1983		25b. REGISTRAR'S SIGNATURE John C. Carty			
Clearspring, Md.															

11. *Leucosia* (Leucosia) *leucostoma* (Fabricius) (Fig. 11)

expired  
11/04/83  
53 am  
M  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												3 3 3 1 2 8 7	
1. FOR STATE REGISTRAR											REG. NO.		
1. DECEASED NAME (TYPE OR PRINT)			FIRST	HELEN	MIDDLE	ROMAIN	LAST	MITCHELL	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR P 9:53 M
3. SEX F			4. RACE W-C	5. DATE OF BIRTH MONTH 7			DAY 23	YEAR 22	6. AGE (IN YEARS LAST BIRTHDAY) 61	IF UNDER 1 YEAR MONTHS YRS.	IF UNDER 24 HRS DAYS	IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE COUNTRY Md. Washington County			7b. CITIZEN OF WHAT COUNTRY? Country U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Washington County			MD.	
10. CITY OR TOWN OF DEATH Hagerstown			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife			12b. KIND OF BUSINESS OR INDUSTRY Home				
13a. STATE Maryland			13b. COUNTY Wash.			13c. CITY OR TOWN Hagerstown			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 21740 907 Lanvale St.	
14. FATHER'S NAME FIRST Fielder Noah			MIDDLE	LAST Selby			15. MOTHER'S MAIDEN NAME FIRST Fanny Elmiria			MIDDLE	LAST "Smith "		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216-14-5493			17. INFORMANT Sharpsburg, Md. 21782 Virginia Kauffman/Rt. #1, Box 309-20			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)</p> <p>PART 1. DEATH WAS CAUSED BY:</p> <p>IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b> 4029</p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</p> <p>(b) <b>HYPERTENSIVE CARDIOVASCULAR DISEASE</b></p> <p>DUE TO, OR AS A CONSEQUENCE OF</p> <p>(c)</p>													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE
22a. I certify that <b>GARY HORWITZ</b> (this hospital) attended the deceased from <b>9 NOV 83</b> to <b>9 NOV 83</b> , that <b>we</b> last saw the deceased alive on <b>19</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <b>GARY HORWITZ</b>			DEGREE MD			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED <b>4 NOV 83</b>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>GARY HORWITZ</b>			22e. ADDRESS <b>WASH COUNTY HOSPITAL</b>										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 11/8/83			23c. NAME OF CEMETERY OR CREMATORIAL Rest Haven Cemetery			23d. LOCATION CITY OR TOWN Hagerstown, Wash. Md.			COUNTY	
24. FUNERAL DIRECTOR NAME Rest Haven Funeral Chapel, Inc. 1601 Pennsylvania Ave. Hagerstown, Md..						25a. DATE REC'D. BY REGISTRAR NOV 9 1983			25b. REGISTRAR'S SIGNATURE <b>John J. Cawley</b>				



1982 Collection

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												31288						
1 - FOR STATE REGISTRAR			REG. NO.															
1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR							
Charles Edward Mulligan Sr.					11	11	83				9 A.M.							
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR			11	26	1913	6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS DAYS								
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Washington			10. CITY OR TOWN OF DEATH Boonsboro		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Reeders Memorial Home			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Brakeman		12b. KIND OF BUSINESS OR INDUSTRY Railroad	
13a. STATE Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 440 George Street		21740							
14. FATHER'S NAME FIRST Daniel		MIDDLE F.		LAST Mulligan			15. MOTHER'S MAIDEN NAME FIRST Mary		MIDDLE Ada		LAST Barger							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. ---		17. INFORMANT Ruth G. Mulligan			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		ADDRESS 440 George Street Hagerstown, Md.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 72 hours							
							DUE TO, OR AS A CONSEQUENCE OF (b) { DUE TO, OR AS A CONSEQUENCE OF (c) Acute myocardial infarction											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: ASCVD, prior CVAs																		
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)														
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE														
22a. I certify that (I) (this hospital) attended the deceased from 9, 1982, to 1983, that (I) (we) last saw the deceased alive on 11/10/83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) see the body after death.												27. DATE SIGNED 11/14/83						
22b. SIGNATURE R.L. Kueger MD		22c. DEGREE MD		22d. ATTENDING PHYSICIAN MD			22e. ADDRESS 100 Geeting Lane Keedysville, Md.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11-14-83		23c. NAME OF CEMETERY OR CREMATORIAL Greenlawn Memorial Pk.			23d. LOCATION CITY OR TOWN Williamsport, Washington, Md.											
24. FUNERAL DIRECTOR NAME A. K. Coffman Funeral Home, Inc., Hagerstown, Md.												25a. DATE REC'D. BY REGISTRAR NOV 17 1983 25b. REGISTRAR'S SIGNATURE John G. Coughlin						



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND 3 3 1 2 8 9 DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												
REG. NO.												
1 - FOR STATE REGISTRAR												
1a DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE			LAST			2a DATE OF DEATH			2b. HOUR	
JANE		E. E.			Myers			11/3/83			10 3 83	
3 SEX		4 RACE			5 DATE OF BIRTH			6 AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR	
FEMALE		WHITE			MONTH DAY YEAR DEC. 4, 1918			64			IF UNDER 24 HRS MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8			9 BALTIMORE CITY OR COUNTY OF DEATH			MD	
Hagerstown, Md.		U.S.A.			MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			WASHINGTON COUNTY				
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Hagerstown		Washington county Hospital						House Wife				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION GIVE RESIDENCE BEFORE ADMISSION)												
13a STATE		13b COUNTY		13c CITY OR TOWN		13d. INSIDE CITY LIMITS?			13e STREET ADDRESS			
Maryland		Washington		Hagerstown		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			21740 433 Washington St.			
14. FATHER'S NAME FIRST		MIDDLE		LAST		15 MOTHER'S MAIDEN NAME FIRST			16 ADDRESS			
Clarence				Hadley		Mary Jane			"Hamburg"			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b SOCIAL SECURITY NO.			17 INFORMANT			18 APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
No		None			Harry C. Myers/Same as 13 e							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY.												
IMMEDIATE CAUSE (a) <u>Hepatostatic Carcinoma of breast</u> 9 years												
DUE TO, OR AS A CONSEQUENCE OF (b) _____												
DUE TO, OR AS A CONSEQUENCE OF (c) _____												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 1979 to 1983, that (I) (we) last saw the deceased alive on 11/3/83 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <u>Clarence A. Hadley</u> DEGREE <u>W.M.</u>												
22c. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED <u>11/11/83</u>										
22e. ADDRESS												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN COUNTY STATE					
Entombment		11/7/83		Rest Haven Cemetery			Hagerstown, Washington, Md.					
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR/REGISTRAR'S SIGNATURE										
Rest Haven Funeral Chapel, Inc.		NOV 9 1983 <u>John C. Clegg</u>										
1601 Pennsylvania Ave. Hagerstown, Md.												

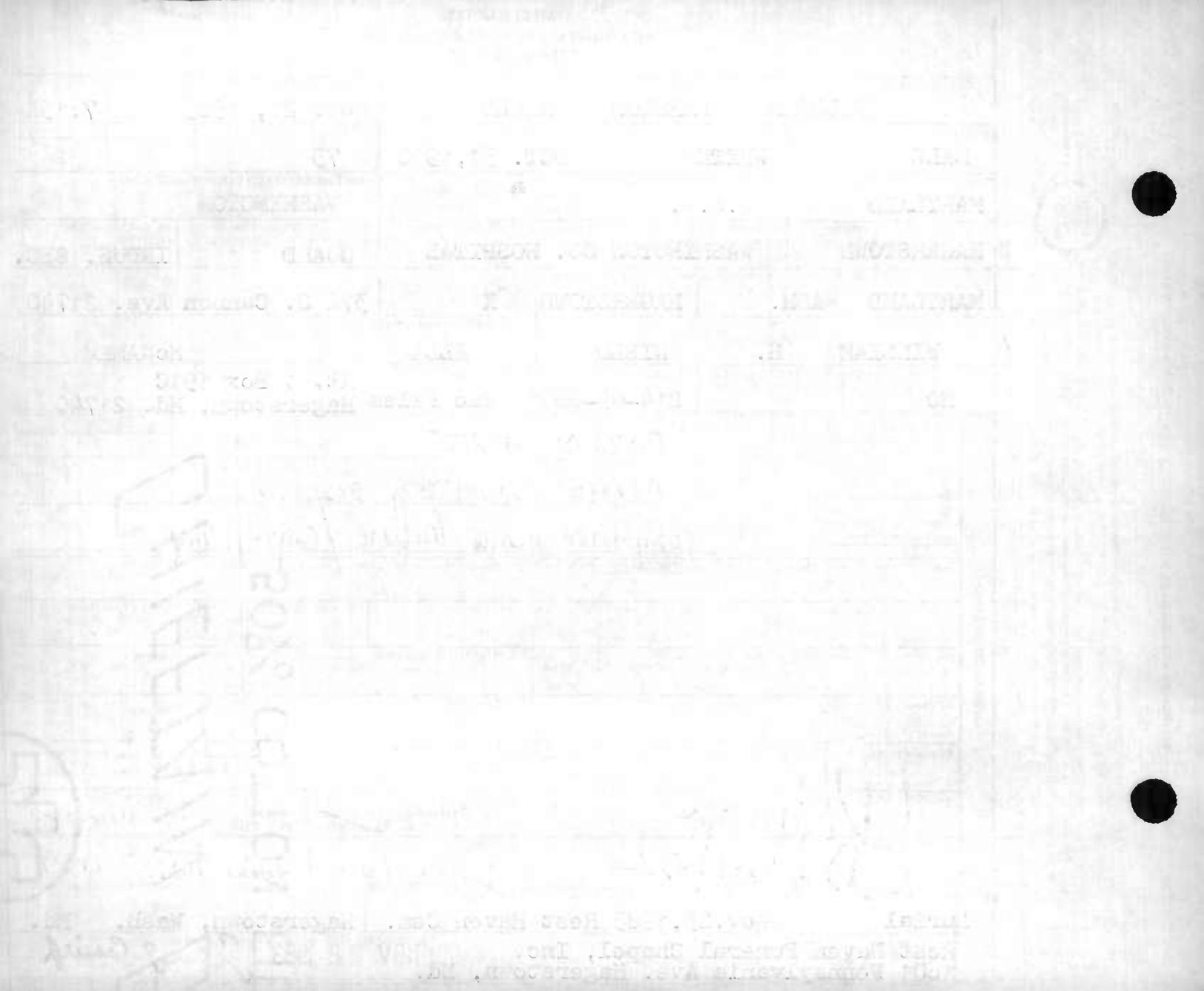
Final Survey 820 even

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the physician, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Page 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
REG. NO. 3 1 2 9 0											
1 - STATE REGISTRAR			1 DECEASED NAME (TYPE OR PRINT)			FIRST WILLIAM PRESTON NIELD			2a. DATE OF DEATH Nov. 21, 1983		
3. SEX MALE			4 RACE WHITE			5. DATE OF BIRTH MONTH DAY YEAR OCT. 31, 1910			6. AGE (IN YEARS LAST BIRTHDAY) 73		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH WASHINGTON		
10. CITY OR TOWN OF DEATH HAGERSTOWN			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SAME FACILITY, GIVE STREET ADDRESS) WASHINGTON CO. HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) GUARD			12b. KIND OF BUSINESS OR INDUSTRY INDUS. SEC.		
13a. STATE MARYLAND			13b. COUNTY WASH.			13c. CITY OR TOWN HAGERSTOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST WILLIAM H. NIELD			15. MOTHER'S MAIDEN NAME FIRST ELLA McNAMEE								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 214-09-8801			17. INFORMANT Sue Fales			ADDRESS Rt. 1 Box 191C Hagerstown, Md. 21740		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4280 <span style="float: right;">APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</span> DUE TO, OR AS A CONSEQUENCE OF (b) Acute respiratory衰弱 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any. <span style="float: right;">(c) congestive heart failure / edema</span> DUE TO, OR AS A CONSEQUENCE OF (c) congestive heart failure / edema											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. MEDICAL CERTIFICATION DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1, OR PART 3)					
21d. INJURY OCCURRED AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (i) (the hospital) attended the deceased from 10/30/83 to 11/21/83 that (ii) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (i) (we) did (did not) view the body after death.											
22b. SIGNATURE			22c. DEGREE			22d. DATE SIGNED 11/21/83					
22e. PHYSICIAN'S NAME (TYPE OR PRINT)			22f. ADDRESS 1825 Howell road Hager ms								
23a. BURIAL, CREMATION, REMOVAL* (SPECIFY) Burial			23b. DATE Nov. 23, 1983			23c. NAME OF CEMETERY OR CREMATORIAL Rest Haven Cem.			23d. LOCATION CITY OR TOWN Hagerstown, Wash. COUNTY Md. STATE		
24. FUNERAL DIRECTOR Rest Haven Funeral Chapel, Inc. 1601 Pennsylvania Ave. Hagerstown, Md.						25a. DATE REC'D. BY REGISTRAR NOV 28 1983			25b. REGISTRAR'S SIGNATURE		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

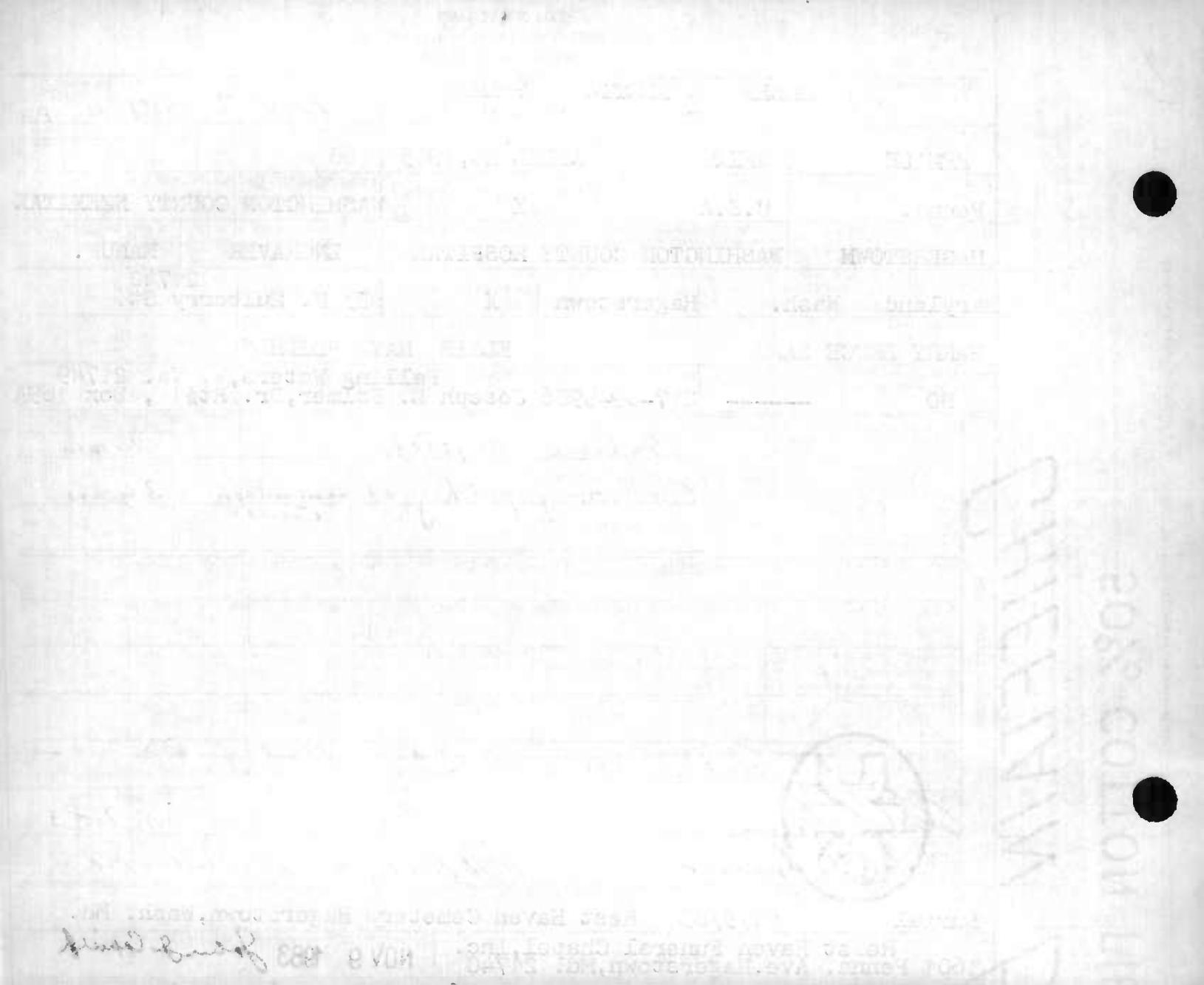
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 31291

1 - FOR STATE REGISTRAR		2a. DATE OF DEATH MONTH DAY YEAR Nov 3, 1983									
1. DECEASED NAME (TYPE OR PRINT) <i>Helen HELEN IILETTA PALMER</i>		2b. HOUR 12:55 PM									
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR APRIL 26, 1915		6. AGE (IN YEARS LAST BIRTHDAY) 68		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Penna.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>WASHINGTON COUNTY</b>		10. CITY OR TOWN OF DEATH <b>HAGERSTOWN</b>			
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>WASHINGTON COUNTY HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>ENGRAVER</b>				12b. KIND OF BUSINESS OR INDUSTRY <b>MANUF.</b>					
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Wash.</b>		13c. CITY OR TOWN <b>Hagerstown</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>21740 623 N. Mulberry St.</b>			
14. FATHER'S NAME FIRST <b>HARRY</b>		MIDDLE <b>BRUCE</b>		LAST <b>KANN</b>		15. MOTHER'S MAIDEN NAME FIRST <b>ELSIE</b>		MIDDLE <b>MAY</b>		LAST <b>"DIEHL"</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>217-09-9986</b>		17. INFORMANT ADDRESS <b>Falling Waters, W. Va. 21749</b>		17. INFORMANT ADDRESS <b>Joseph L. Palmer, Sr./Rt#1, Box 169A</b>					
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4254</b> <i>Cardiac asystole</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>30 min.</b>											
DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cardiomyopathy of uncertain cause</b> 3 years.											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: o											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (the hospital) attended the deceased from 1980 to 1983, that (I) (we) last saw the deceased alive on 11-3-1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.											
22b. SIGNATURE <i>Charles C. Spencer</i>		22c. DEGREE <i>MD</i>		22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22e. DATE SIGNED <b>11-3-83</b>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Charles C. Spencer</b>		22e. ADDRESS <b>1198 Kenly Ave Hagerstown Md.</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11/5/83</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Rest Haven Cemetery</b>		23d. LOCATION CITY OR TOWN <b>Hagerstown, Wash. Md.</b>					
24. FUNERAL DIRECTOR NAME <b>Rest Haven Funeral Chapel, Inc.</b>		25. DATE REC'D. BY REGISTRAR NAME <b>NOV 9 1983</b>		25b. REGISTRAR'S SIGNATURE <i>John G. Coughlin</i>							
ADDRESS <b>1601 Penna. Ave. Hagerstown, Md. 21740</b>											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be resubmitted by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 24 hours after death.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner and the medical examiner's office should be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND				DEPARTMENT OF HEALTH AND MENTAL HYGIENE				CERTIFICATE OF DEATH			
1 - FOR STATE REGISTRAR								REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)		FIRST <i>HARVEY</i>	MIDDLE <i>MILTON</i>	LAST <i>PITTENGER</i>	2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR				
3. SEX <i>m</i>		4. RACE <i>Cauc.</i>		5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY) <i>89</i>		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN		
10. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Fred. Co.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <i>Wash.</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>FARMER</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Factory worker</i>		
10. CITY OR TOWN OF DEATH <i>Hagerstown</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>COLTON VILLA</i>		13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE <i>Md.</i> 13c. COUNTY <i>Fred.</i> 13d. CITY OR TOWN <i>Rocky Ridge</i>		13e. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13f. STREET ADDRESS <i>14726 B Motter Station Rd.</i>			
14. FATHER'S NAME FIRST <i>George</i>		MIDDLE <i>Washington</i>	LAST <i>Pittenger</i>	15. MOTHER'S MAIDEN NAME FIRST <i>Catherine</i>		MIDDLE <i>Smith</i>	LAST <i>Engle</i>	16a. WAS DECEASED EVER IN U.S. ARMED FORCES (YES, NO OR UNKNOWN) <i>WW I Yes</i>		16b. SOCIAL SECURITY NO. <i>220-10-5609</i>	
17. INFORMANT <i>Mrs. Cora Setherley</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <i>4275</i> IMMEDIATE CAUSE (a) <i>Cardiac arrest</i>		17. INFORMANT <i>Mrs. Cora Setherley</i>		18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Abdul W. Ateeq</i>		22c. DEGREE <i>MD</i>		ATTENDING PHYSICIAN	MEDICAL DIRECTOR	STAFF PHYSICIAN	22d. DATE SIGNED <i>11/11/83</i>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>ABDUL W. ATEEQ MD</i>		22e. ADDRESS <i>1600 Oak Hill NE, HAG, MD</i>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>11/14/83</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Creagerstown Cemetery</i>		23d. LOCATION CITY OR TOWN <i>Creagerstown, Frederick, Md.</i>		STATE <i>MD</i>			
24. FUNERAL DIRECTOR <i>John G. Smith</i>		24b. ADDRESS <i>615 E. Main St.</i>		25a. DATE REC'D. BY REGISTRAR/SD. REGISTRAR'S SIGNATURE <i>NOV 23 1983 John G. Smith</i>							
24c. FIRM <i>R. E. Smith &amp; Son, P. H. Marton</i>		24d. CITY OR TOWN <i>Thurmont, Md.</i>									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 2



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Page 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										31295			
										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR
Edwin						Poling		November		30	1983		1 A.M.
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS			
Male		White		September 4, 1914		69		MONTHS	YRS	MONTHS	YRS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		WASHINGTON			
West Virginia		U.S.A.											
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Hagerstown		WESTERN MARYLAND CENTER		Excursion Dept.		Celanese Corp.							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS					
Md. - 21502		Allegany		Cumberland		YES <input checked="" type="checkbox"/>		948 Frederick Street					
14. FATHER'S NAME		FIRST		LAST		15. MOTHER'S MAIDEN NAME		LAST					
Ira				Poling		Maude		Ramsey					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		(IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
Yes		W.W.II		217-10-4359		Margaret Louise Poling-Address same as #13.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
4100 Cardiorespiratory arrest										30 minutes			
DUE TO, OR AS A CONSEQUENCE OF (b) Acute myocardial infarction													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Coronary artery disease													
DUE TO, OR AS A CONSEQUENCE OF (c) Coronary artery disease										many years			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a													
CVA, History of myocardial infarction in 1975													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>							
21b. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN							
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 11/16 19 83 to 11/30 19 83, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 11/30 19 83, and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input type="checkbox"/> (We) <input type="checkbox"/> did <input type="checkbox"/> did not view the body after death.						COUNTY STATE							
22b. SIGNATURE F. E. U. Porciuncula		DEGREE M.D.		ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 11/30/83							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) F. E. U. Porciuncula, M.D.		22e. ADDRESS 1500 Pennsylvania Avenue, Hagerstown, MD											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/2/83		23c. NAME OF CEMETERY OR CREMATORIAL Hillcrest Burial Park		23d. LOCATION CITY OR TOWN Cumberland-Allegany Co.-Md.							
24. FUNERAL DIRECTOR NAME George Upchurch Funeral Home, P.A. 202 Greene Street-Cumberland, Maryland 21502				25a. DATE REC'D. BY REGISTRAR DEC 09 1983		25b. REGISTRAR'S SIGNATURE John J. Conner							



10 MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, AND PAGE 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR RECAVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO.				
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF DEATH ESTIMATED			MONTH	DAY	YEAR	2b. HOUR				
Ruth M. Price						<input checked="" type="checkbox"/>			Nov 13 1983	7 A	M					
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR. MONTHS DAYS			8. IF UNDER 24 HRS. HOURS MIN			2c. DATE PRONOUNCED DEAD	MONTH	DAY	YEAR	2d. HOUR
Female	White	June 8, 1895			88 yrs.							Nov 13 1983	7 A	M		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH							
Paragould, Ark.			U. S. A.						Washington							
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
Boonsboro			Fahrney- Keedy Memorial Home			Secretary			U. S. Gov.							
13a. STATE Virginia			13b. COUNTY Fairfax			13c. CITY OR TOWN Alexandria			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 4901 Seminary Rd. 22311				
14. FATHER'S NAME FIRST			MIDDLE			15. MOTHER'S MAIDEN NAME FIRST			MIDDLE			LAST				
Patrick			Lemuel			Markin			Julia			Anne Huckelby				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS							
No			319- 03-8472			Barbara P. Armstrong, Boonsboro, Md. 2171			Rfd. 1 Box 388A							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:  4292 Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.  (b)  (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH yrs				
IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF																
DUE TO, OR AS A CONSEQUENCE OF (b)																
DUE TO, OR AS A CONSEQUENCE OF (c)																
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).  Fracture RT Humerus																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?										
—			—			<input type="checkbox"/> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE										
22a. I certify that I took charge of the remains described above, held an death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/>													
ACTUAL SIGNATURE			H. H. Weeks			TITLE (SPECIFY) M.D. Dep MEDICAL EXAMINER			DATE SIGNED Nov 13 83							
EXAMINER'S NAME (TYPE OR PRINT)			H. H. Weeks			ADDRESS			580 Northern Av Hagerstown Md							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE 11-14-83			23c. NAME OF CEMETERY OR CREMATORIAL Georgetown Unvi.			23d. LOCATION CITY OR TOWN Washington			23e. COUNTY D. C. STATE				
Removal- Donation																
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE							
John H. Bast, Jr.			Boonsboro, Md. 21713			NOV 17 1983			John J. Cawley							

Missouri Dept. of Natural Resources, 1970, 1:250,000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3  
retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3  
should be detached for use on the burial/transit permit. Then please remove carbon paper. Pages 2 and 2 should be filed with the  
State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND 31295 DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH															
REG. NO.															
1 - FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		Margaret Louise L. Pryor		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR				
		Margaret		Louise L. Pryor		11-20-83		11-20-83	11-20-83	11-20-83	1:15 P.M.				
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS					
Female		White		MONTH 11 - DAY 27 - YEAR 18		64		MONTHS		DAYS					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8		MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		MD.					
Maryland		U.S.A.						Washington							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (IF NOT IN SUCH FACILITY, GIVE WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY									
Hagerstown		Western Maryland Center		Housekeeper		Homes									
13a. STATE MD		13b. COUNTY Wash.		13c. CITY OR TOWN Smithsburg		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS Rt. 1, Box 4		21783					
14. FATHER'S NAME FIRST Jacob		MIDDLE -		LAST Pryor		15. MOTHER'S MAIDEN NAME FIRST Lucy		MIDDLE -		LAST Kendall					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS									
no		220-18-1029		Mrs. Evelyn M. Lewis, Smithsburg, MD											
18. CAUSE OF DEATH PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Cardiorespiratory arrest minutes													
1732 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, last.		DUE TO, OR AS A CONSEQUENCE OF (b) Cancer 1st ear DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. Diabetes mellitus Hypertension, cardiovascular disease															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?									
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE					
22a. I certify that <input checked="" type="checkbox"/> this hospital attended the deceased from 11/19/83 to 11/20/83, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 11/20/83, and that in (my) <input type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input type="checkbox"/> did not <input type="checkbox"/> view the body after death.															
22b. SIGNATURE Florence P. Palomo		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 11/20/83					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS 1500 Lane Av Hagerstown MD 21701													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11-23-83		23c. NAME OF CEMETERY OR CREMATORIAL Smithsburg Cemetery		23d. LOCATION CITY OR TOWN Smithsburg, Wash., MD		COUNTY		STATE					
24. FUNERAL DIRECTOR Davis Funeral Home, Smithsburg, MD, 21783		25a. DATE REC'D. BY REGISTRAR NOV 28 1983		25b. REGISTRAR'S SIGNATURE C. M. & Company											

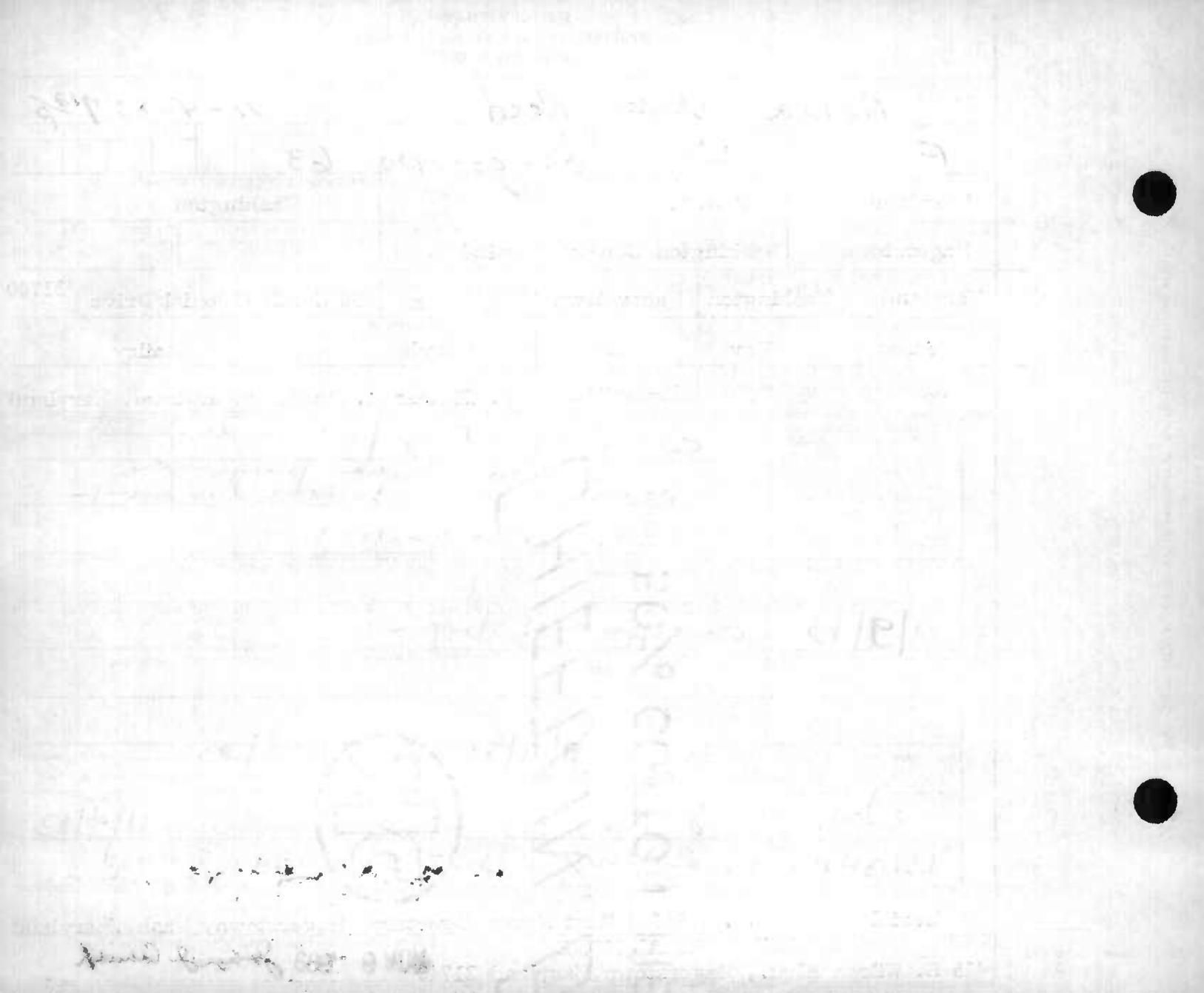
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.						
1 - FOR STATE REGISTRAR																		
1. DECEASED NAME (TYPE OR PRINT)			FIRST Nelda			MIDDLE Venetta			LAST Reed			2a. DATE OF DEATH MONTH 11 - 4 - 83		2b. HOUR 7:13 p.m.				
3. SEX F			4. RACE W			5. DATE OF BIRTH MONTH 09 - 03 - 1920			YEAR			6. AGE (IN YEARS LAST BIRTHDAY) YRS. 63		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8			MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH Washington		MD.				
10 CITY OR TOWN OF DEATH Hagerstown			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY									
13a. STATE Maryland			13b. COUNTY Washington			13c. CITY OR TOWN Hagerstown			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS 30 South Colonial Drive		21740				
14. FATHER'S NAME FIRST Amos			MIDDLE Ray			LAST Ruth			15. MOTHER'S MAIDEN NAME FIRST Mary			MIDDLE Bailey			LAST			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215-20-9245			17. INFORMANT			ADDRESS			Mr. Thomas R. Reed, Hagerstown, Maryland						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1419 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last															ANTERIOR INJURY BETWEEN DEATH AND DEATH			
DUE TO, OR AS A CONSEQUENCE OF (b) massive gastrointestinal hemorrhage																		
DUE TO, OR AS A CONSEQUENCE OF (c) carcinoma of tongue																		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a																		
19a. DATE OF OPERATION 9/9/83			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED carcinoma of tongue			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)												
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE					
22a. I certify that (I) (this hospital) attended the deceased from 9/7/83 19 to 11/3/83 19, that (I) (we) last saw the deceased alive on 11/3/83 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.															22b. DATE SIGNED 11/9/83			
22b. SIGNATURE Dr. S. Bandy MD			22c. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>												
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BISHAS C. BANDY			22e. ADDRESS 363-5. Cleveland Ave. Hagerstown															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial			23b. DATE Nov. 8, 1983			23c. NAME OF CEMETERY OR CREMATORIAL Rest Haven Cemetery			23d. LOCATION CITY OR TOWN Hagerstown, Wash., Maryland									
24. FUNERAL DIRECTOR MINNICH FUNERAL HOME NAME 415 E. Wilson Blvd., Hagerstown, Maryland 21740						25a. DATE REC'D. BY REGISTRAR NOV 9 1983			25b. REGISTRAR'S SIGNATURE Howard Gandy									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, then please remove carbon copies. Page 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury or other traumatic event, the medical examiner must be notified or contact the State Dept. of Health and Mental Hygiene.

## MEDICAL CERTIFICATION

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
Edward Ellsworth Robison CERTIFICATE OF DEATH

31291

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH				2b. HOUR			
Edward ELLSWORTH Robison				11 10 83				10:38 p.m.			
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	7. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH	10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Male	White	MONTH DAY YEAR 11 06 07	76	U.S.A.			Washington County	Hagerstown	Washington County Hospital	Self Employed	Trucking Co.
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS			21740				
Maryland	Washington	Hagerstown		124 John Street							
14. FATHER'S NAME	FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME							
	Edward	S.	Robison	Alice							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)				
Yes	WW II	193-03-9444	Dolly M. Cross			Route # 5 Box 280 Hagerstown, Md.	18 months				
DUE TO, OR AS A CONSEQUENCE OF (b)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a											
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET				CITY OR TOWN	COUNTY	STATE			
22a. I certify that (I) (this hospital) attended the deceased from 11/10/83 to 11/10/83, that (I) (we) lost saw the deceased alive on 11/10/83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE	22c. DEGREE				22d. DATE SIGNED						
Robert Brull	MD				ATTENDING PHYSICIAN <input type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	11/11/83			
22e. PHYSICIAN'S NAME (TYPE OR PRINT)	22f. ADDRESS				22g. ADDRESS						
Robert Brull	1459 Potomac Ave.				1459 Potomac Ave.						
23a. BURIAL, CREMATION, REMOVAL BUREAU	23b. DATE	23c. NAME OF CEMETERY OR CREMATORIUM	23d. LOCATION CITY OR TOWN	23e. COUNTY	23f. STATE						
Burial	11-14-83	Broadfording Cemetery	nr. Hagerstown	Washington	Md.						
24. FUNERAL DIRECTOR NAME	25a. DATE REC'D. BY REGISTRAR'S OFFICE										
A. K. Coffman Funeral Home, Inc., Hagerstown, Md.	NOV 17 1983										



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 31298

1. DECEASED NAME (TYPE OR PRINT) <b>Margaret Margaret M. Rohrer</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>11 18 83</b>	2b. HOUR <b>4 PM</b>
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Sept. 20, 1912</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>71</b>	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Keedysville, Md.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>Washington</b>	MD.	
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington County Hospital</b>			12a. USUAL OCCUPATION (TYPE OR WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>
13a. STATE <b>Maryland</b>	13b. COUNTY <b>Washington</b>	13c. CITY OR TOWN <b>Hagerstown</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>327 Pangborn Blvd. 21740</b>	
14. FATHER'S NAME FIRST <b>Victor</b>	MIDDLE <b>Charles</b>	LAST <b>Poffenberger</b>	15. MOTHER'S MAIDEN NAME FIRST <b>Phoebe</b>	MIDDLE	<b>Haller</b>
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>	16b. SOCIAL SECURITY NO. <b>214-09-2528B</b>	17. INFORMANT <b>Mr. Daniel S. J. Rohrer, Hagerstown, Md.</b>	ADDRESS <b>327 Pangborn Blvd.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Yes</b>					
4140 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE
22a. I certify that (I) (this hospital) attended the deceased from <b>10-20, 1980</b> , to <b>11-18, 1983</b> , that (I) (we) last saw the deceased alive on <b>11-8, 1983</b> , and that in (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>John H. Hornbaker, Jr. M. D.</b>			DEGREE	22c. DATE SIGNED <b>11-18-83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>John H. Hornbaker, Jr. M. D.</b>			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22e. ADDRESS <b>645 E. First St. Hagerstown, Md. 21740</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>11-21-83</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Cedar Lawn Me. Park</b>	23d. LOCATION CITY OR TOWN <b>Hagerstown, Wash. Co., Md.</b>	25a. DATE REC'D. BY REGISTRAR <b>NOV 22 1983</b>	
24. FUNERAL DIRECTOR NAME <b>John H. Bast, Jr. Boonsboro, Md. 21713</b>			25b. REGISTRAR'S SIGNATURE <b>John G. Lohr</b>		



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, AND 3 TO THE FUNERAL DIRECTOR.  
 TO FUNERAL DIRECTOR: PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. RETAIN PAGE 5 FOR YOUR USE.  
 AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND 3 31299  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. \_\_\_\_\_

1. DECEASED NAME (TYPE OR PRINT)			FIRST		MIDDLE		LAST		2a. DATE KNOWN OF ESTI- MATED		MONTH	DAY	YEAR	2b. HOUR 9 AM									
<i>Mitchell Allen</i>							<i>Rudy</i>		<input checked="" type="checkbox"/>		11	6	1983	9 AM									
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY) YRS.		7. IF UNDER 1 YR. MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD		2d. HOUR 9 AM									
male		white		Nov. 14, 1908		74						11 6 1983		9 AM									
9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED WIDOWED		9. NEVER MARRIED DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH															
Maryland		U.S.A.		<input type="checkbox"/>		<input type="checkbox"/>		Washington															
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK) FOR MOST OF WORKING LIFE		12b. KIND OF BUSINESS OR INDUSTRY																	
Hagerstown		Washington County Hospital		maintenance		Aircraft																	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS		21740													
Maryland		Washington		Hagerstown		YES <input checked="" type="checkbox"/>		117 East Lee Street															
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS													
Jerome		Lula		H.W. II		yes		Mr. Carl E. Rudy, Hagerstown, Maryland		Poffenberger													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19. DATE OF OPERATION		20. AUTOPSY?		21. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		22. TIME OF INJURY HOUR <input checked="" type="checkbox"/> MONTH DAY YEAR		23. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		24. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		25. PLACE OF INJURY (AT HOME STREET, FACTORY, FARM, ETC.)		26. LOCATION STREET		27. CITY OR TOWN		28. COUNTY		29. STATE	
PART 1 DEATH WAS CAUSED BY:  <i>4140</i>		IMMEDIATE CAUSE (a)  <i>Cardiac arrest 427</i>		DUE TO, OR AS A CONSEQUENCE OF  <i>Arterio sclerotic heart disease 414</i>		DUE TO, OR AS A CONSEQUENCE OF  <i>Diabetes mellitus 250</i>		21b. TIME OF INJURY 8 P.M. 11 6 1983		21c. HOW INJURY OCCURRED  <i>Cardiac arrest</i>		21d. PLACE OF INJURY (AT HOME STREET, FACTORY, FARM, ETC.)  <i>Home</i>		21e. LOCATION STREET  <i>117 E Lee St Hagerstown</i>		21f. CITY OR TOWN  <i>Washgto</i>		21g. COUNTY  <i>md</i>		21h. STATE  <i>md</i>			
22a. I certify that I took charge of the remains described above, held an death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		23a. ACTUAL SIGNATURE  <i>Allen W. D. II</i>		23b. DATE SPECIFY Nov. 8, 1983		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Rose Hill Cemetery		23d. LOCATION CITY OR TOWN Hagerstown, Wash., Maryland		24. FUNERAL DIRECTOR NAME MINNICH FUNERAL HOME		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE 415 E. Wilson Blvd., Hagerstown, Maryland 21740 Nov 9 1983 <i>George Clegg</i>											
BP _____		EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS 1610 Oak Hill Ave Hagerstown																			
DHMH - 17 (VR A15 ME (5)) 15M 2/80																							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and certified by the physician, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be retained by the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH													
REG. NO. 3 3 1 300													
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH			MONTH DAY YEAR		2b. HOUR		
Leon Cyril Sanzel			Leon Cyril SANZEL			11-16-83			9:20 P.M.				
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS (LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS	
MALE		White		MONTH 12 DAY 22 YEAR 1910			72			MONTHS YRS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8.		9. BALTIMORE CITY OR COUNTY OF DEATH						
Rochester, NY		U.S.A.			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		Washington County						
11. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Boonesboro		Fahrney-Keedy Home			DRUG STORE MGR.			21740					
13. USUAL RESIDENCE (IE NURSING HOME OR OTHER INSTITUTION. GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS					
MD		Washington		Hagerstown		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1104 Hamilton Blvd.					
14. FATHER'S NAME		FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME			ADDRESS						
Philip		— SANZEL		Esther			1104 Hamilton Blvd.						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.			17. INFORMANT			Hagerstown, Md. 21740					
Yes - Navy		073-03-5673			Lieba J. Cohen			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> 2500 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any: (b) <u>Atherosclerotic cardiovascular disease</u> (c) <u>Diabetes mellitus - severe</u>													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): <u>Acute myocardial infarction, renal failure</u>													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?						
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AI WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE		
22a. I certify that (I) (the hospital) attended the deceased from saw the deceased alive on 4/14 19 83, and that in (my) <u>law</u> opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.		22b. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED					
22d. PHYSICIAN'S NAME, TITLE, DEPARTMENT		George C. Newman II, Ph.D., MD											
22e. ADDRESS		1825 Howell Road, Hagerstown, Maryland											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIUM			23d. LOCATION CITY OR TOWN		23e. DATE REC'D. BY REGISTRAR			23f. REGISTRAR'S SIGNATURE	
Burial		11-18-83		Beth Joseph Cemetery			Rochester, Monroe, New York		NOV 28 1983			John J. Conigli	
24. FUNERAL DIRECTOR NAME		ADDRESS											
A.K. Coffman Funeral Home, Inc., Hagerstown, Md.													

Issue list no 1



1976-07-01  
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified at all times.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												31301	
1 - STATE REGISTRAR											REG. NO.		
1. DECEASED NAME (TYPE OR PRINT)			FIRST		MIDDLE		LAST		2a. DATE OF DEATH			2b. HOUR	
MAUD			Lila		Seaman				11-29-83			12 PM	
3. SEX			4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS	
Female			White		MONTH 4 DAY 14 YEAR 1891		92			MONTHS 0 DAYS 0		YRS. 0	
9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			MD.			
Maryland			USA				Washington						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Hagerstown			Washington County Hospital		buyer			dept. store					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)													
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS				
Maryland		Washington		Hagerstown		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			920 Dewey Avenue 21740				
14. FATHER'S NAME			MIDDLE		LAST		15. MOTHER'S MAIDEN NAME			LAST			
James			A.		Seaman		Nannie			Lakin			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT			ADDRESS					
No			214-09-0570		Martha Seaman, Hagerstown, Md.								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)													
4280												Overdose corr.	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.													
DUE TO, OR AS A CONSEQUENCE OF (b)												Congestive heart failure	
DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
							YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY P.M.		21c. HOW INJURY OCCURRED HOUR A.M. MONTH DAY YEAR		(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
				19									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from 11-29-83 to 11-29-83, that (I) (we) last saw the deceased alive on 11-28-83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE				DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED					
				and				11/28/83					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS											
Abdul Sattar		1600 Oak Hill Ave. Hagerstown 21740											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN		23e. COUNTY		23f. STATE		
burial		Dec. 2, 1983		Rest Haven Cemetery			Hagerstown, Wash., Maryland						
24. FUNERAL DIRECTOR MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740												25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
												DEC 2 1983	John J. Cawie

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached to use on the burial permit. Then please remove carbon paper. Pages 4 and 7 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified or source

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												31302											
REG. NO.																							
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2d. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR					
Irene			Serbe									November 17, 1983						970P M					
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR			8. IF UNDER 24 HRS.								
Female			White			MONTH Jan. DAY 15, YEAR 1900			83			MONTHS			DAYS			HOURS					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			10. CITY OR TOWN OF DEATH			NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			11a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Maryland			U.S.A.						Washington County			Williamsport			Homewood Retirement Center			Housewife			MD.		
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS			14. ADDRESS			15. MOTHER'S MAIDEN NAME					
Maryland			Prince Geo			Silver Hill			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			3206 Lassie Avenue			20023			Catherine			M. Spalding		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			19. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
No			579-34-0043						Arteres Alerentu Heart Disease														
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			(b)			DUE TO, OR AS A CONSEQUENCE OF			(c)														
DUE TO, OR AS A CONSEQUENCE OF																							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																							
20a. DATE OF OPERATION			20b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20c. AUTOPSY			20d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?														
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)																	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT HOME <input type="checkbox"/> WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE								
22a. I certify that (i) this hospital attended the deceased from <u>11-16</u> to <u>11-17</u> , 19 <u>83</u> , that (ii) we last saw the deceased alive on <u>11-16</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (i) (we) did not view the body after death.																							
22b. SIGNATURE			22c. DEGREE			22d. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. DATE SIGNED														
Sidney W. Venstein			MD															11-18-83					
22f. PHYSICIAN'S NAME (TYPE OR PRINT)						22g. ADDRESS																	
Burial			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			23e. COUNTY			23f. STATE								
11/21/83			Washington National Cemetery						Suitland			PG			Maryland								
24. FUNERAL DIRECTOR			NAME			ADDRESS			25. DATE RECEIVED BY REGISTRAR			25b. REGISTRAR'S SIGNATURE											
Robert E. Wilhelm			4308						NOV 21 1983			George Smith											
Funeral Home			Suitland Road			Suitland Maryland																	

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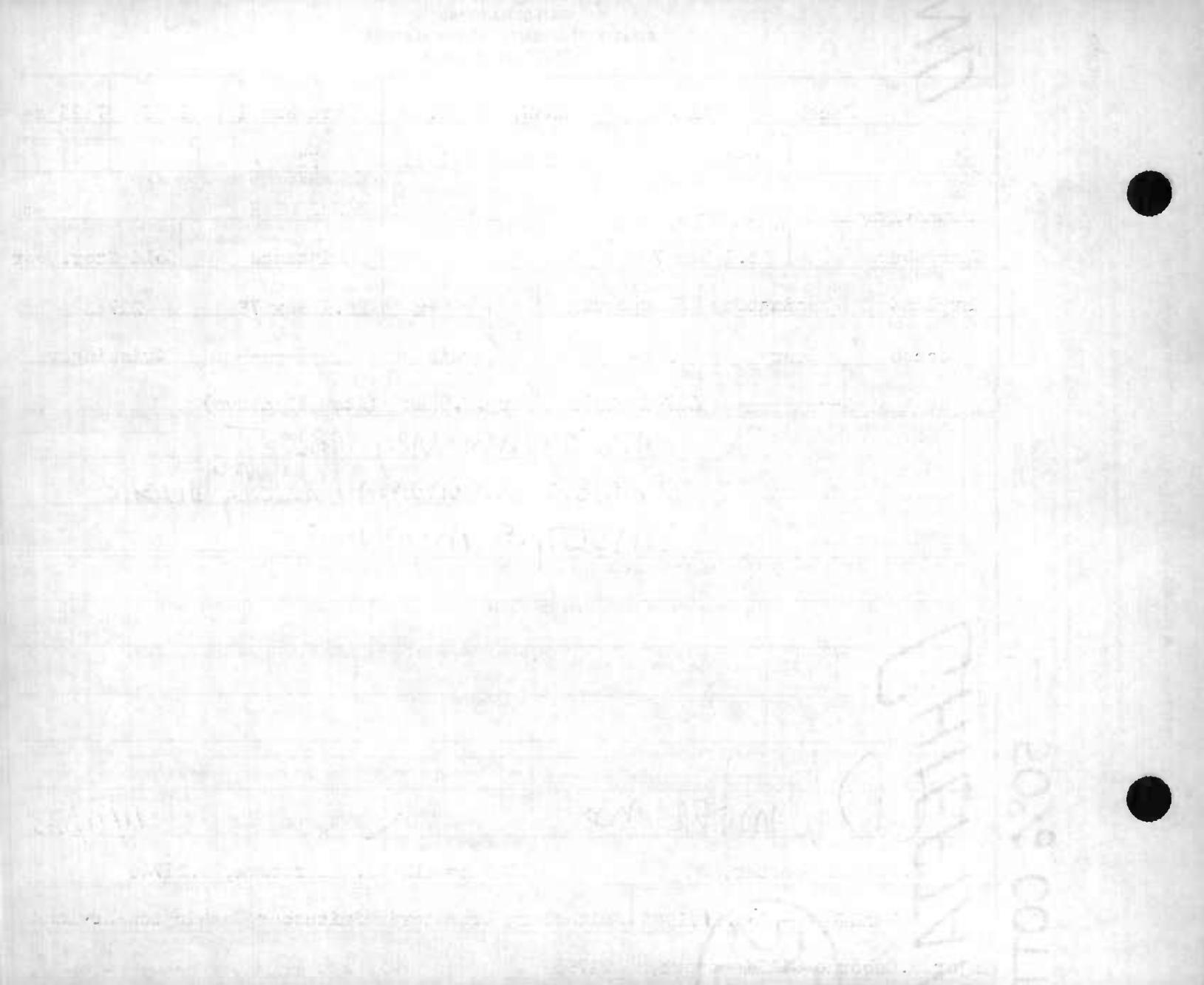
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon paper. Page 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 is blank, any injury or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND 83 DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 31303
1 - STATE REGISTRAR				
1. DECEASED NAME (TYPE OR PRINT)		FIRST Jacob	MIDDLE William	LAST SHAW, Sr.
2. DATE OF DEATH		MONTH November	DAY 10	YEAR 1983
3. SEX		4. RACE White		7b. HOUR 7:25 a.m.
5. DATE OF BIRTH MONTH September		DAY 7	YEAR 1911	6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS
7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH WASHINGTON MD.
10. CITY OR TOWN OF DEATH Sharpsburg		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Rt. 1 Box 78		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Maintenance
13a. STATE Maryland		13b. COUNTY Washington	13c. CITY OR TOWN Sharpsburg	12b. KIND OF BUSINESS OR INDUSTRY Cold Stor. Door
14. FATHER'S NAME FIRST Jacob		MIDDLE Henry	LAST Shaw	15. MOTHER'S MAIDEN NAME FIRST Bertie
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 217-10-2973		17. INFORMANT Mary. M. Shaw (item 13 above)
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 2030		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any.		DUE TO, OR AS A CONSEQUENCE OF (b) <i>probable pneumonia</i> / <i>coronary artery disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>multiple myeloma</i> -		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN COUNTY STATE
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE <i>D. Wooster, MD</i>		DEGREE	22c. DATE SIGNED 11/11/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) L. Dwight Wooster, MD		22e. ADDRESS 1825 Howell Rd. Hagerstown, MD. 21740		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE Nov. 11, 1983	23c. NAME OF CEMETERY OR CREMATORIAL Smithsburg Crematorium	23d. LOCATION CITY OR TOWN Smithsburg
24. FUNERAL DIRECTOR NAME Major M. Osborne Williamsport, MD 21795		25a. DATE REC'D. BY REGISTRAR NOV 14 1983		25b. REGISTRAR'S SIGNATURE <i>John G. Conard</i>



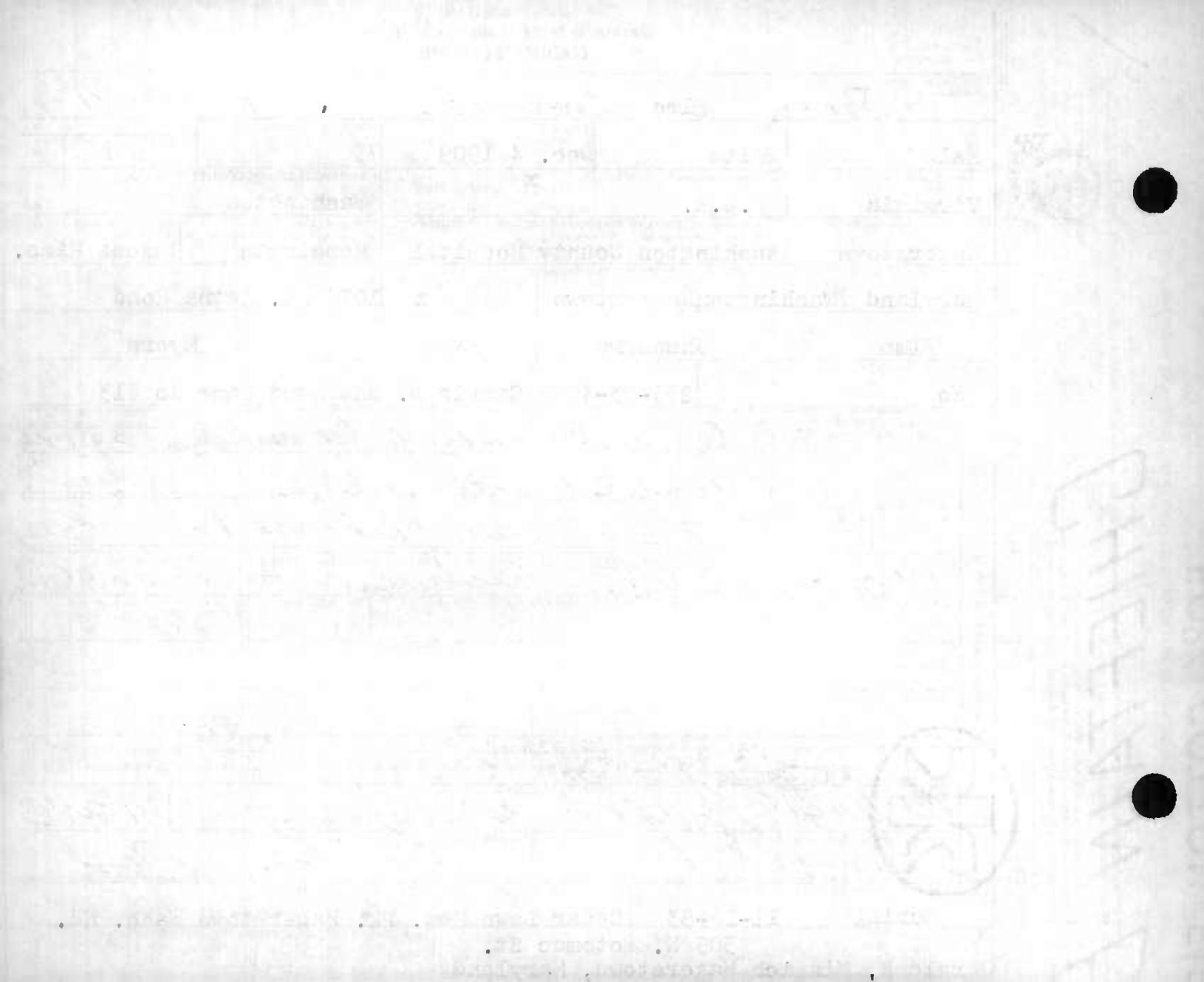
TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the physician, it should be detached for use on the burial permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be paged.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												83	31304				
												REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR					
James Elmo Shepherd						11 13 83						9:30 PM					
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR					
Male			White			Dec. 4 1909			73			MONTHS DAYS					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			IF UNDER 24 HRS.					
Virginia			U.S.A.						Washington			YRS.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			MD					
Hagerstown			Washington County Hospital			Repairman			Rescue Miss.			21740					
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS					
Maryland			Washington			Hagerstown						1075 Mt. Aetna Road					
14. FATHER'S NAME			FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME											
Elmo			Shepherd			Mary											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS								
			235-03-4997			Carrie E. Shepherd Same as #13											
18. CAUSE OF DEATH: Enter only one cause per line for 18a, b, and c. PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4340</i>												APPROXIMATE INTERVAL BETWEEN INJURY AND DEATH					
Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause (c) <i>Cerebral thrombosis left hemiplegia</i>												3-4 yrs					
DUE TO, OR AS A CONSEQUENCE OF <i>Arterial atherosclerosis</i>												years					
DUE TO, OR AS A CONSEQUENCE OF <i>Arteriosclerotic cardiovascular disease</i>												years					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. <i>Hypertension C.V.I. - Alcoholism - Hx alcohol &amp; glaucoma</i>																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 21a, PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input type="checkbox"/>								
22a. INJURY OCCURRED AT HOME <input type="checkbox"/> NOT AT HOME <input type="checkbox"/> AT WORK <input type="checkbox"/>			22b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			22c. LOCATION STREET			CITY OR TOWN			COUNTY STATE					
23a. I certify that (i) (this hospital) attended the deceased from <i>15 June 74</i> to <i>date</i> , 19 <i>83</i> , to <i>date</i> , 19 <i>83</i> , that (ii) (we) last saw the deceased alive <i>3 mo</i> 19 <i>83</i> and that (iii) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (i) (we) and (ii) (we) did not view the body after death.																	
23b. SIGNATURE <i>William J. Binford</i>												DEGREE	ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	23c. DATE SIGNED <i>14 Nov 83</i>			
22a. PHYSICIAN'S NAME (TYPE OR PRINT)			22b. ADDRESS			23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIUM			23d. LOCATION CITY OR TOWN		
Binford			Hagerstown, MD			Burial			11-16-83			Cedar Lawn Mem. Pk.			Hagerstown Wash. Md.		
24. FUNERAL DIRECTOR NAME			ADDRESS			25. DATE REC'D. BY REGISTRAR OR REGISTRAR'S SIGNATURE						305 N. Potomac St.			NOV 17 1983 John G. Minnich		
Gerald N. Minnich			Hagerstown, Maryland														



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 days with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND 83 DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 31305												
1 - STATE REGISTRAR			REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	
Alice A. Shilling			Alice	Amelia	SHILLING	11-11-83			11	11	83	
3. SEX			4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)			2b. HOUR		
female			white		April 30, 1904		79			11 AM		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		
Maryland			USA				Washington			12b. KIND OF BUSINESS OR INDUSTRY		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12c. CITY OR TOWN		13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS		
Hagerstown			Washington County Hospital		Chewsville		YES <input type="checkbox"/> NO <input type="checkbox"/>			P. O. Box 5 21721		
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			16. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
Joseph			C.		Longnecker	Laura			Ellen Pound			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS				
No			215-34-3820		Jean Recher, Chewsville, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for 1a, b, and c.)												
PART I. DEATH WAS CAUSED BY:												
IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u>												
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebral Thrombosis &amp; Left hemiplegia.</u> 6 days.												
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Diabetes mellitus.</u> 5 yrs.												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.												
19a. MEDICAL CERTIFICATION			19b. DATE OF OPERATION			19c. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
									YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 10 21 1983			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <u>Fell at home &amp; fractured left hip.</u>						
21d. INJURY OCCURRED AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE
22a. I certify that (1) (this hospital) attended the deceased from saw the deceased alive on 11-11-1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) did (did not) view the body after death.			22b. SIGNATURE <u>Charles F. Hess</u>			22c. DEGREE <u>M.D.</u>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED 11-11-83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS									
Charles F. Hess M.D.			Smithsburg, Md.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION			
burial			Nov. 14, 1983			Smithsburg Cemetery			CITY OR TOWN Smithsburg, Wash., Maryland			
24. FUNERAL DIRECTOR MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740						25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			
						NOV 17 1983			<u>John J. Cawley</u>			

standard, 89.010

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												31300			
												REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)			FIRST Wilbur			MIDDLE Powell			LAST SHRY			2a. DATE OF DEATH MONTH November	DAY 20, 1983	YEAR	2b. HOUR 1:48 P M
3. SEX male			4. RACE white			5. DATE OF BIRTH MONTH September			DAY 17, 1903			6. AGE (IN YEARS LAST BIRTHDAY) MONTHS 80	IF UNDER 1 YEAR MONTHS YRS	IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia			7b. CITIZEN OF WHAT COUNTRY? USA			8			MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Washington			MD.
10. CITY OR TOWN OF DEATH Hagerstown			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) printer			12b. KIND OF BUSINESS OR INDUSTRY						
13a. STATE Maryland			13b. COUNTY Washington			13c. CITY OR TOWN Hagerstown			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 1421 Salem Avenue			
14. FATHER'S NAME FIRST Charles			MIDDLE			LAST Shry			15. MOTHER'S MAIDEN NAME FIRST Bertha			MIDDLE LAST Fry			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-09-7268			17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 - 6 HRS.			
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4100</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>CARDIOGENIC SHOCK FOLLOWING ACUTE M.I.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												15 - 20 YEARS			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE		
22a. I certify that (1) <u>(X)</u> attended the deceased from <u>Nov. 20</u> , 19 <u>83</u> , to <u>Nov. 20</u> , 19 <u>83</u> , that (1) <u>(X)</u> last saw the deceased alive on <u>Nov. 20</u> , 19 <u>83</u> , and that in (my) <u>(X)</u> opinion death occurred on the date and hour and from the causes stated above, (1) <u>(X)</u> did not view the body after death.												22c. DATE SIGNED Nov. 21, 1983			
22b. SIGNATURE <u>Edward W. Ditto</u>			22c. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. ADDRESS 217 WEST WASHINGTON STREET HAGERSTOWN, MARYLAND 21740						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) EDWARD W. DITTO, III, M.D.															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial			23b. DATE Nov. 23, 1983			23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Rest Haven Cemetery			23d. LOCATION CITY OR TOWN Hagerstown, Wash., Maryland			COUNTY	STATE		
24. FUNERAL DIRECTOR NAME MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740									25a. DATE REC'D. BY REGISTRAR NOV 25 1983			25b. REGISTRAR'S SIGNATURE <u>John J. Coyle</u>			

• 14 • TRAITS OF A GOOD LEADER

2016 RELEASE UNDER E.O. 14176

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Т-САУНД, ИМОТКАРД

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified of same.

## MEDICAL CERTIFICATION

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND 83  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH 31307

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST Gilbert R.	MIDDLE Shumaker	LAST	2a. DATE OF DEATH MONTH Nov 29 1983	DAY 5 P.M.	YEAR	2b. HOUR 5 00
3. SEX Male		4. RACE Cauc.	5. DATE OF BIRTH MONTH Jan. 4, 1933 DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY) 50		IF UNDER 1 YEAR MONTHS YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Sharpsburg, Md.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington		
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN THIS FACILITY, GIVE STREET ADDRESS) Washington County Hospital			12a. USUAL OCCUPATION Painter			12b. KIND OF BUSINESS OR INDUSTRY Home Construction	
13a. STATE Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Fairplay		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Rfd. 1 Box 26 21733	
14. FATHER'S NAME FIRST Edward		MIDDLE L.	LAST Shumaker		15. MOTHER'S MAIDEN NAME FIRST Edith		MIDDLE M.	LAST Shoppert	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 217-30-5919			17. INFORMANT Mrs. Thelma M. Shumaker, Fairplay, Md.		ADDRESS Rfd. 1 Box 26		
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> APPROXIMATE INTERVAL 4100 BETWEEN ONSET AND DEATH <1 hrs Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a house									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET		CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>Nov 15 1983</u> to <u>Nov 29 1983</u> , that (I) (we) last saw the deceased alive on <u>Nov 15 1983</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>ME Byrkit</u>					DEGREE		22c. DATE SIGNED Nov 29, 1983		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ME Byrkit					22e. ADDRESS Williamsport Md				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-2-83		23c. NAME OF CEMETERY OR CREMATORIAL Cedar Lawn Mem. Park			23d. LOCATION CITY OR TOWN Hagerstown, Wash. Co., Md.		
24. FUNERAL DIRECTOR NAME John H. Bast, Jr.		ADDRESS Boonsboro, Maryland 21713		25a. DATE REC'D. BY REGISTRAR DEC 5 1983		25b. REGISTRAR'S SIGNATURE <u>John H. Bast, Jr.</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												31308		
												REG. NO.		
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR		
Howard (NMN)					Smith	11 22 83					83	6:30 AM		
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS		
MALE		White		MONTH	9	DAY	22	YEAR	68	YRS.	MONTHS	DAYS	HOURS	MIN.
7a. BIRTHPLACE (STATE OR COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			10. CITY OR TOWN OF DEATH				
MD. Frederick Co.		USA		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			Washington County			Hagerstown				
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY						
Wash. County Hospital				Operator				Land Fill						
13a. STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS				
Md				Washington		Hagerstown		X		835 W. Franklin Street				
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME			16. SOCIAL SECURITY NO.			17. INFORMANT				
WILLIAM				FIRST	MIDDLE	LAST	213-18-8232			Doris J. Smith				
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)				19. ADDRESS			20. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
2051				835 West Franklin Street			Hagerstown, Md. 21740							
Conditions, if any, which gave rise to immediate cause 1a, stating the underlying cause last.				ETTA MAY KLINE										
DUE TO, OR AS A CONSEQUENCE OF (b) Acute leukemia - blast crisis														
DUE TO, OR AS A CONSEQUENCE OF (c) from chronic myelogenous leukemia														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a														
Carcinoma of the sigmoid colon														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE			
22a. I certify that (I) (this hospital) attended the deceased from 11-11-1980 to 11-22-1983, that (I) (we) last saw the deceased alive on 11-22-1983, and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input type="checkbox"/> (we) <input type="checkbox"/> did not view the body after death.														
22b. SIGNATURE			DEGREE			22c. DATE SIGNED								
George Newman II Ph.D M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>											
22d. PHYSICIAN'S NAME (TYPE)			22e. ADDRESS											
George C. Newman II PH.D MD.			1825 Howell Road, Hagerstown, Md. 21740											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN					
Burial			11-26-83			Mt. Bethel Church Cemetery, Foxville, Washington, Md.			COUNTY					
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE					
A. K. Coffman Funeral Home, Inc., Hagerstown, Md.						NOV 28 1983			John J. Coffman					

1940 Census of Population, United States, 1940. Vol. 1. General Population. U.S. Bureau of the Census, Washington, 1943.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, then please remove carbon paper. Pages 1 and 2 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 3 and 4 should be retained by the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner shall be notified and the medical examiner shall be retained by the hospital or attending physician.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
3 1 3 0 9											REG. NO.
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR		
VIRGINIA A. SNYDER						NOVEMBER 14 1983			8 05 P.M.		
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
FEMALE		WHITE		Jan. 19, 1910			73 YRS.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			10. CITY OR TOWN OF DEATH	
West Virginia		U.S.A.					Washington			Hagerstown	
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)											
Washington Co. Hospital											
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)											
Retail											
12b. KIND OF BUSINESS OR INDUSTRY											
Sales											
13a. STATE Maryland											
13b. COUNTY Wash.		13c. CITY OR TOWN Hagerstown			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 810 Marshall St. 21740			
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST								
George Robert Snyder			Daisy Irene Shoemaker								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH YEARS		
NO			214-09-5283			Paul Garryn Hagerstown, Md 21740			20 W. Baltimore St.		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) CHRONIC RENAL FAILURE 4039											
DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIOCAR NEPHROSCLEROSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, lost.											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a). ANTERIOPSCIOTIC HEART DISEASE											
19a. DATE OF OPERATION NONE		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED AT HOME <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE
22a. I certify that (I) (this hospital) attended the deceased from 19 69, to NOVEMBER 14 19 83, that (I) (we) last saw the deceased alive on NOVEMBER 14 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Barry M. Cohen		DEGREE MD			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 11-15-83			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Barry M. Cohen		22e. ADDRESS 339 E. ANTIETAM ST HAGERSTOWN, MD, 21740									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11/17/83		23c. NAME OF CEMETERY OR CREMATORIAL Rest Haven Cem.			23d. LOCATION CITY OR TOWN Hagerstown		COUNTY	STATE	
24. FUNERAL DIRECTOR Rest Haven Funeral Chapel, Inc. 1601 Pennsylvania Ave., Hagerstown, Md.					25a. DATE REC'D. BY REGISTRAR NOV 18 1983			25b. REGISTRAR'S SIGNATURE See G. Cohen			

1. 1980 and 1981 1982  
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323. 2946 2947 2948  
324. 2949 2950 2951  
325. 2952 2953 2954  
326. 2955 2956 2957  
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337. 2988 2989 2990  
338. 2991 2992 2993  
339. 2994 2995 2996  
340. 2997 2998 2999  
341. 3000 3001 3002  
342. 3003 3004 3005  
343. 3006 3007 3008  
344. 3009 3010 3011  
345. 3012 3013 3014  
346. 3015 3016 3017  
347. 30

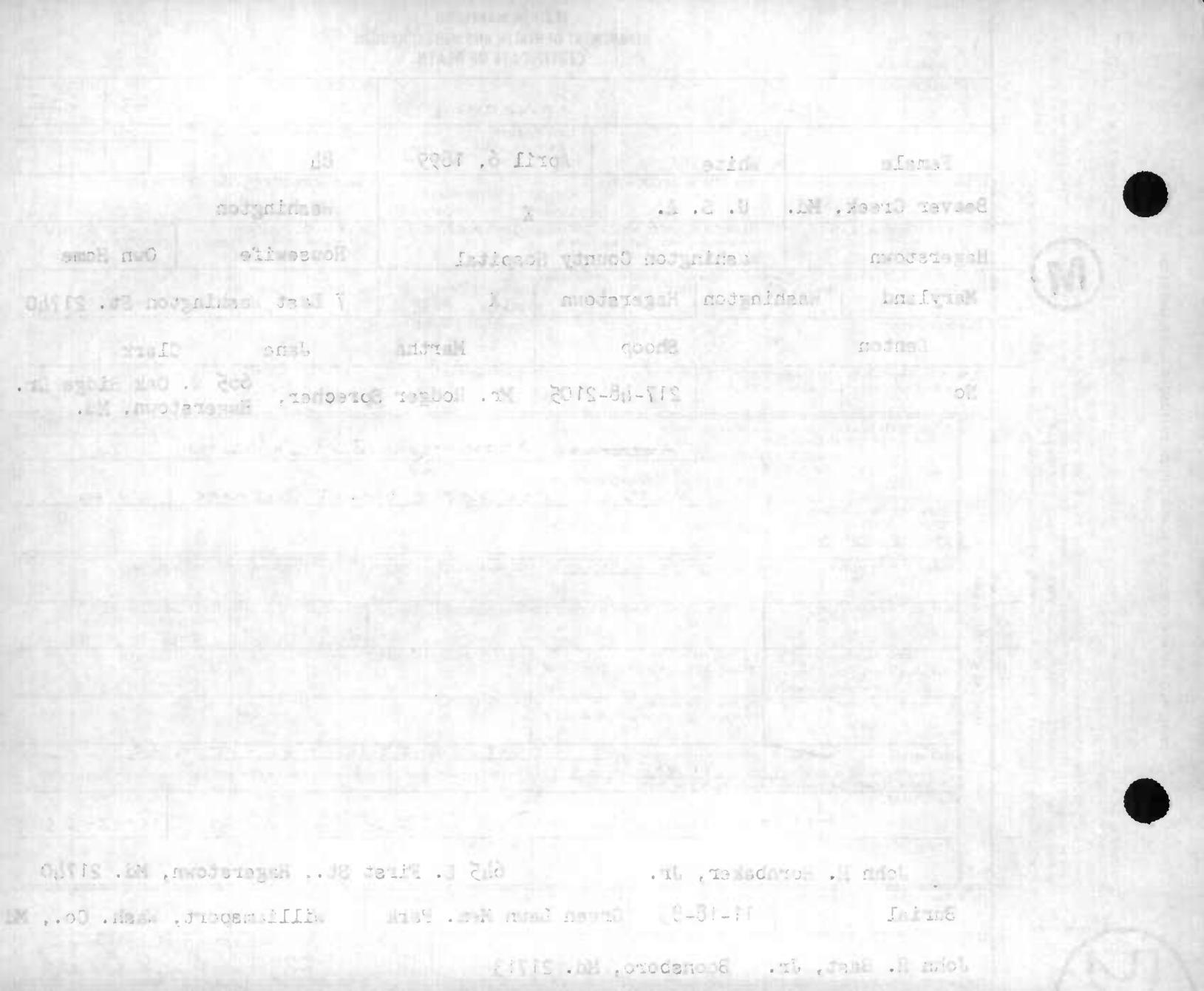
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be detached for use as the burial transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner should be consulted at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 3331310									
1. FOR STATE REGISTRAR		2. DECEASED NAME (TYPE OR PRINT)				FIRST		MIDDLE		LAST		20. DATE OF DEATH		MONTH	DAY	YEAR	26. HOUR		
		ADA				A				Sprecher		11		15	83	P 45			
3. SEX		4. RACE		5. DATE OF BIRTH				6. AGE (IN YEARS LAST BIRTHDAY)				IF UNDER 1 YEAR		IF UNDER 24 HRS					
Female		White		MONTH April DAY 6, 1899 YEAR				84				YEARS		MONTHS DAYS HOURS MIN.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input type="checkbox"/>		NEVER MARRIED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH									
Beaver Creek, Md.		U. S. A.				WIDOWED <input type="checkbox"/>		DIVORCED <input type="checkbox"/>		Washington									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY									
Hagerstown		Washington County Hospital				Housewife				Own Home									
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS									
Maryland		Washington		Hagerstown						7 East Washington St. 21740									
14. FATHER'S NAME		FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME				16. WAS DECEASED EVER IN U.S. ARMED FORCES? NO (S. NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)				16b. SOCIAL SECURITY NO. 217-48-2105				17. INFORMANT		ADDRESS	
Denton		Shoop		Martha Jane Clark												Mr. Rodger Sprecher, Hagerstown, Md.		665 W. Oak Ridge Dr.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4100 Acute myocardial Infarction 2d				DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerotic Heart Disease 42a				DUE TO, OR AS A CONSEQUENCE OF (c)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>				20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
22a. I certify that (I) (this hospital) attended the deceased from 11-13 19 83 to 11-15 19 83, that (I) (was last saw the deceased alive on 11-15 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																			
22b. SIGNATURE John H. Hornbaker, Jr.		DEGREE				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 11-15-83									
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS																	
John H. Hornbaker, Jr.		645 E. First St., Hagerstown, Md. 21740																	
23a. BURIAL, CREMATION, REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL				23d. LOCATION CITY OR TOWN COUNTY STATE											
Burial		11-18-83		Green Lawn Mem. Park				Williamsport, Wash. Co., Md.											
24. FUNERAL DIRECTOR		NAME John H. Bast, Jr.				ADDRESS Boonsboro, Md. 21713				25a. DATE REC'D. BY REGISTRAR NOV 21 1983				25b. REGISTRAR'S SIGNATURE John J. Conley					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical certifier must be notified at once.

STATE OF MARYLAND 83 DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												3131											
1. FOR STATE REGISTRAR			REG. NO.																				
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR					
Raymond R			Raymond			Russell			Staley			Nov 20 83			83	20	83	7:10 P.M.					
3. SEX Male			4. RACE White			5. DATE OF BIRTH Month 9 Day 22 Year 1915			6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS.			7. IF UNDER 1 YEAR MONTHS 0 DAYS 0			8. IF UNDER 24 HRS HOURS 7 MIN. 10								
7a. BIRTHPLACE Country U.S. Maryland			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH WASHINGTON			10. CITY OR TOWN OF DEATH Hagerstown			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WASHINGTON COUNTY Hospital			12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) Retired Owner			12b. KIND OF BUSINESS OR INDUSTRY Auto Salvage		
13a. STATE Md.			13b. COUNTY Wash.			13c. CITY OR TOWN Williamsport			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS Route 2 Box 306			21795								
14. FATHER'S NAME FIRST Franklin			MIDDLE David			LAST Staley			15. MOTHER'S MAIDEN NAME FIRST Mary			MIDDLE -----			LAST Palmer								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b. SOCIAL SECURITY NO. 215-09-7330			17. INFORMANT Dorothy H. Staley (item 13 above)																	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerotic accident right renal artery</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
4360 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																							
DUE TO, OR AS A CONSEQUENCE OF (b) <i>ante myocardial infarction</i>																							
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Disease mellitus</i>																							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>ante myocardial infarction</i> , <i>Disease mellitus</i>																							
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>														
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)																	
21d. INJURY OCCURRED AT HOME <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE								
22a. I certify that (I) (the hospital) attended the deceased from <i>19-20</i> to <i>11-20</i> , 1983, that (I) (the hospital) saw the deceased alive on <i>4-20</i> , 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																							
22b. SIGNATURE <i>Charles J. Spencer MD</i>												DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 11-21-83					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Charles J. Spencer</i>			22e. ADDRESS <i>198 Kelly Ave Hagerstown MD</i>																				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Nov. 23, 1983			23c. NAME OF CEMETERY OR CREMATORIAL Greenlawn Mem. Park			23d. LOCATION CITY OR TOWN Williamsport			COUNTY Washington			STATE Maryland								
24. FUNERAL DIRECTOR NAME Major M. Osborne/P.O.Bx#348/Williamsport, MD 21795			25a. DATE REC'D. BY REGISTRAR NOV 25 1983			25b. REGISTRAR'S SIGNATURE <i>John J. Lach</i>																	



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, AND 3 TO 4 HOURS IN ALL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3, RETAIN A COPY FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE KEPT WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												31312			
												REG. NO.			
1 - STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)			MIDDLE			LAST			2a. DATE KNOWN OF ESTI- MATED	MONTH	DAY	YEAR	2b. HOUR
		Albert William Starliper									Nov 12	19	83	50	
		1. SEX Male	4. RACE W	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 yr. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		2c. DATE PRONOUNCED DEAD	MONTH	DAY	YEAR	2d. HOUR	
				1/5/1922	61 yrs.					Nov 12	19	83	50		
		7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH						
		Maryland		U.S.A.					WVNSA						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Hagerstown		Washington County						Engineer			Engineering				
13a. STATE Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Big Pool		13d. INSIDE CITY LIMITS YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS RFD-1 Box 143A		21711					
14. FATHER'S NAME FIRST Harry		MIDDLE L.		LAST Starliper		15. MOTHER'S MAIDEN NAME FIRST Hilda		MIDDLE Levinia		LAST Davis					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. WW-2		17. INFORMANT Mrs. Theda Kieffer		ADDRESS Big Pool, MD									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 4100 IMMEDIATE CAUSE (a) <u>Coronary occlusion (410)</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> lying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 50 days			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE				
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE <i>J. H. Weeks</i>		TITLE (SPECIFY) M.D. <i>Dr. J. H. Weeks</i> MEDICAL EXAMINER										DATE SIGNED <i>Nov 12 83</i>			
EXAMINER'S NAME (TYPE OR PRINT) <i>J. H. Weeks</i>		ADDRESS <i>580 Northern Av Hagerstown</i>													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Nov. 15, 83			23c. NAME OF CEMETERY OR CREMATORIUM Mountain View			23d. LOCATION CITY OR TOWN Sharpsburg		COUNTY Wash.	STATE Md.				
24. FUNERAL DIRECTOR <i>Donald E. Thompson</i>								25a. DATE REC'D. BY REGISTRAR NOV 18 1983		25b. REGISTRAR'S SIGNATURE <i>John J. Cawley</i>					
Thompson Funeral Home Clearspring Md.															

Spotted sandpiper 200 B. I. V. W. and became 100% brownish

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked with an 'X' shows any injury, or other traumatic event, the medical examiner will be notified or called.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH													
1 - FOR STATE REGISTRAR											REG. NO. 313		
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
Marsha K. Stein						11/22/83			11:45 P.M.				
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS	
Female		WHITE		MONTH DAY YEAR			26			MONTHS	DAYS	HOURS	MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.			
JAPAN		U.S.A.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK OR WORKING LIFE)			Washington COUNTY			
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12b. KIND OF BUSINESS OR INDUSTRY			13a. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			STUDENT			
13a. STATE MD.		13b. CITY OR TOWN MONTG.		13c. STREET ADDRESS WESTERN MARYLAND CENTER			13d. STREET ADDRESS 9500 EDGELEY RD. 20817						
14. FATHER'S NAME FIRST: MARVIN		MIDDLE: ---		15. MOTHER'S MAIDEN NAME STEIN			16. ADDRESS			MAWRY			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT			18. CAUSE OF DEATH PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)			9500 EDGELEY RD. BETHESDA, MARYLAND			
NO		NONE		MR. MARVIN STEIN			cardiorespiratory arrest			2391 minute			
DUE TO, OR AS A CONSEQUENCE OF (b) congestive heart failure			DUE TO, OR AS A CONSEQUENCE OF (c) lymphangiomyomatosis lungs/1982							minute			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1b.													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE		
22a. I certify that (s) (this hospital) attended the deceased from 3/19 1983 to 11/22 1983, that (s) (we) last saw the deceased alive on 11/22 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death. XX													
22b. SIGNATURE Florecita P. Palomo		22c. DEGREE			22d. DATE SIGNED 11/23/83								
22e. PHYSICIAN'S NAME Florecita P. Palomo		22f. ADDRESS Western Maryland Center Hager											
23a. BURIAL/CREMATION, REMOVAL (SPECIFY)		23b. DATE CREMATION 11-26-83		23c. NAME OF CEMETERY OR CREMATORIAL LEE CREMATORY			23d. DATE REC'D. BY REGISTRAR NOV 28 1983			23e. DATE WASHINGON, D.C.			
24. FUNERAL DIRECTOR NAME DANZANSKY-GOLDBERG MEM CHP, INC.		24b. ADDRESS 1170 ROCKVILLE PK. ROCKVILLE MD.			24c. REGISTRAR'S SIGNATURE George J. Conard								



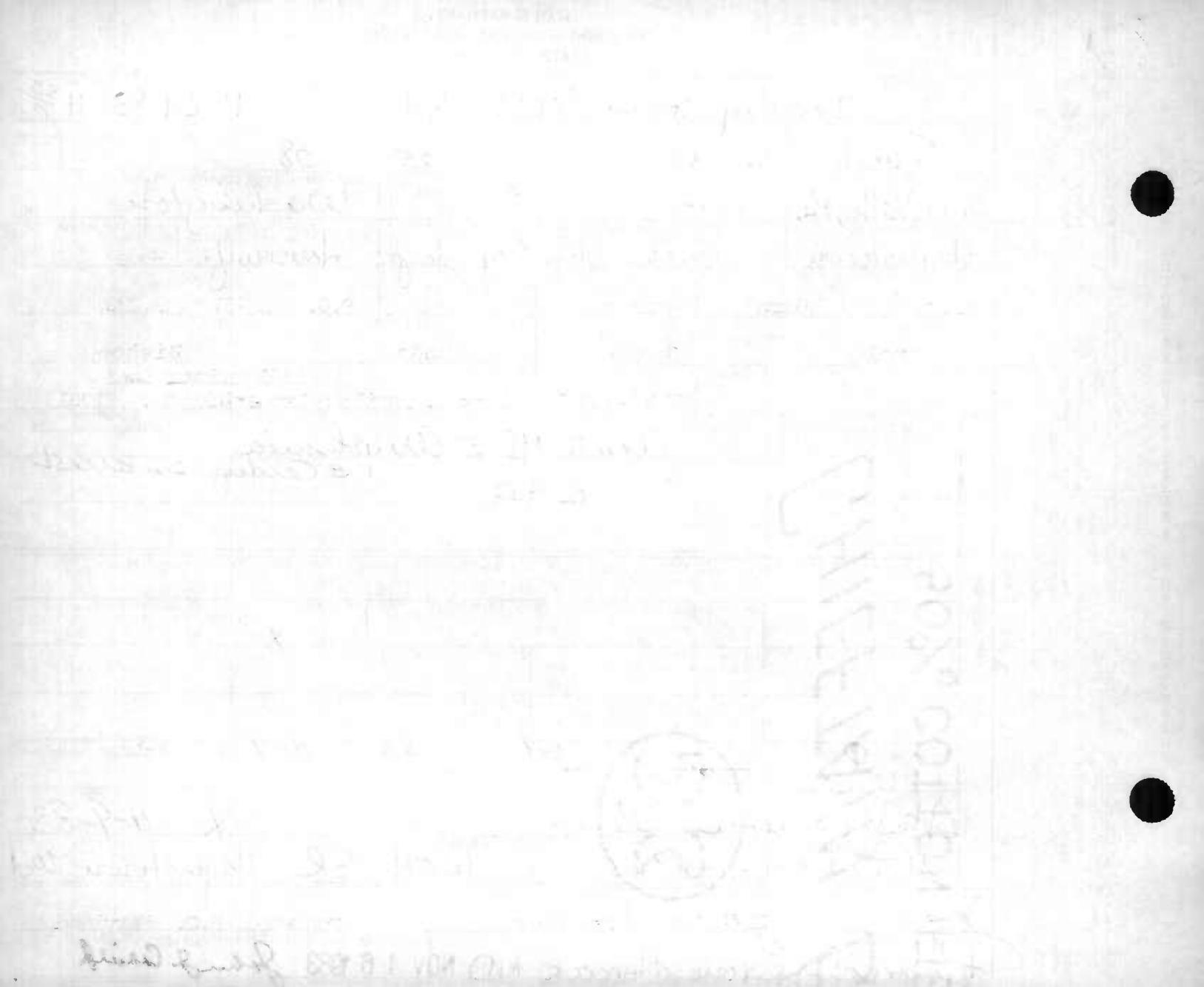
TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked on Item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										31314				
										REG. NO.				
1. DECEASED NAME (TYPE OR PRINT)			FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR
Dorothy Beatrice SULLIVAN									11 09 83				83	11 35 P.M.
3. SEX Female			4. RACE Caucasian		5. DATE OF BIRTH MONTH 3		DAY 26		YEAR 25		6. AGE (IN YEARS LAST BIRTHDAY) 58		IF UNDER 1 YEAR YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Buck Valley, Pa.			7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/>		NEVER MARRIED <input type="checkbox"/>		WIDOWED <input type="checkbox"/>		DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington	
10. CITY OR TOWN OF DEATH Hagerstown			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home							
13a. STATE Penns.			13b. COUNTY Fulton		13c. CITY OR TOWN Needmore		13d. INSIDE CITY LIMITS YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS P.O. Box 157		17238			
14. FATHER'S NAME Harold			15. MOTHER'S MAIDEN NAME Spade		16. SOCIAL SECURITY NO. 213-24-5261		17. INFORMANT Robert C. Hamilton		18. ADDRESS 1551 Andover Lane Frederick, Md. 21701		LAST Bishop			
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4100</u> DO NOT, OR AS A CONSEQUENCE OF (b) <u>Acute MI &amp; Arrhythmia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <u>&amp; Cardiopulm arrest</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>11-9</u> , 19 <u>83</u> , to <u>11-9</u> , 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>11-9</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.														
22b. SIGNATURE <u>M.J. Cannon M.D.</u>			22c. DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22d. DATE SIGNED <u>11-9-83</u>					
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <u>M.J. Cannon M.D.</u>			22f. ADDRESS <u>WCH ER Hagerstown, Md</u>											
23a. BURIAL, CREMATION, REMOVAL METHOD Burial			23b. DATE 11/12/83			23c. NAME OF CEMETERY OR CREMATORIAL Ft. Lincoln			23d. LOCATION CITY OR TOWN Brentwood		COUNTY	STATE P.G. Maryland		
24. FUNERAL DIRECTOR NAME <u>Richard J. Cannon</u>			ADDRESS <u>2100 Hancock Rd Hagerstown, MD</u>			25a. DATE REC'D. BY REGISTRAR NOV 16 1983			25b. REGISTRAR'S SIGNATURE <u>John J. Carroll</u>					
DHMH - 16 50M 4/82 (VRA 15, 4)														



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical certification must be completed before the certificate is signed.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 31315	
1 - FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR Nov. 13, 1983							2b. HOUR M	
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			ESTHER HELEN SWORD					
3. SEX Female			4. RACE White			5. DATE OF BIRTH MONTH DAY YEAR April 20, 1938			6. AGE (IN YEARS LAST BIRTHDAY) 45 YRS.		
7a. BIRTHPLACE COUNTRY Maryland			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Washington County MD.		
10. CITY OR TOWN OF DEATH Hagerstown			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Route # 4 Box 170-A			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife			12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Maryland			13b. COUNTY Washington			13c. CITY OR TOWN Hagerstown			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Harry C. Mills			15. MOTHER'S MAIDEN NAME Susanna E. Drury			13e. STREET ADDRESS Route # 4 Box 170-A			21740		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 212-38-8536			17. INFORMANT Paul E. Sword			17. ADDRESS Route # 4 Box 170-A Hagerstown, Md. 21740		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			DUE TO, OR AS A CONSEQUENCE OF (b) arteriol sclerotic cardiovascularis DUE TO, OR AS A CONSEQUENCE OF (c) morbid obesity						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 20 min.		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: morbid obesity											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN COUNTY STATE		
22a. I certify that (this hospital) attended the deceased from 19 79 to Nov 13 19 83, that (we) lost saw the deceased alive on Nov 19 83, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I/we) (did) (did not) view the body after death.											
22b. SIGNATURE L WALDRON M.D.			22c. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 11/14/83		
22e. PHYSICIAN'S NAME (TYPE OR PRINT) L WALDRON M.D.			22f. ADDRESS 138 E. Antrim St. Hagerstown Md.								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 11-16-83			23c. NAME OF CEMETERY OR CREMATORIAL Pinesburg Mennonite Cemetery			23d. LOCATION CITY OR TOWN Pinesburg, Washington, Md.		
24. FUNERAL DIRECTOR A.K. COFFMAN Funeral Home, Inc., Hagerstown, Md.						25a. DATE REC'D. BY REGISTRAR NOV 17 1983			25b. REGISTRAR'S SIGNATURE John G. Coffman		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner may be notified of one.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												83	31316										
												REG. NO.											
1. FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR		
			Taylor			Charles			W						11 - 5 - 1983			1:20 PM					
3. SEX			4. RACE			5. DATE OF BIRTH									6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS			
Male			white			MONTH 5 DAY 26 YEAR 1892									91			MONTHS	YEARS				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>						9. BALTIMORE CITY OR COUNTY OF DEATH			MD.					
WV.			USA												Washington County								
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)						12b. KIND OF BUSINESS OR INDUSTRY											
Hagerstown			Avolan Manor									National Fruit			Apples								
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS			21740								
Maryland			Washington			city						74 Antietam Drive											
14. FATHER'S NAME FIRST			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME FIRST			MIDDLE			LAST								
James						Taylor			Laura			May			Taylor								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
yes			235 12 1832A			Hagerstown, Maryland			(a) IMMEDIATE CAUSE			Heart Failure			week								
									(b) DUE TO, OR AS A CONSEQUENCE OF Pneumonia: Electrolyte Imbalance						4 weeks								
									(c) DUE TO, OR AS A CONSEQUENCE OF														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?														
None			-						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. none 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)																	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.) none			21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE									
22a. I certify that (I) (this hospital) attended the deceased from June 3, 1981, to Nov 5, 1983, that (I) (we) lost sow the deceased alive on Nov 3, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death																							
22b. SIGNATURE			DEGREE			22c. DATE SIGNED																	
William W. Lesh, M.D.																							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORI			23d. LOCATION CITY OR TOWN														
Burial			11/8/83			Green Hill			Martinsburg, WV. 25401														
24. FUNERAL DIRECTOR NAME			815 W. King Street			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE											
Louis W. Kogelstadt									Nov 16 1983			John J. Coughlin											

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 contains 2 signatures. Fill in the funeral director, page 3 with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows only injury, or other traumatic event, the medical certificate of death should be completed at time of death.

STATE OF MARYLAND 3 DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 31317														
REG. NO.														
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR					
Gail C. Timmons						11 27 83			1:00 P.M.					
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		
Female		White		8 22 1896			87 yrs							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Washington Co., MD.							
Penns.		USA												
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Co. Hosp.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife			12b. KIND OF BUSINESS OR INDUSTRY Own Home						
13a. STATE Pa.		13b. COUNTY Franklin		13c. CITY OR TOWN Mercersburg			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS 13826 Ft. Loudon Rd.				
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST												
Daniel M. Smith		Myra Angle												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			19. TIME INTERVAL BETWEEN ONSET AND DEATH				
No							Branchopneumonia							
4140														
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.														
		(b) CONGESTIVE Heart Failure												
		(c) ATHEROSCLEROTIC HEART DISEASE												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a Cerebral vascular Accident														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
							YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from 11/20 19 83 to 11/27 19 83, that (I) (we) last saw the deceased alive on 11/27 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE Dina J. Delaportas		DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 11/27/83						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dina J. DELAPORTAS MD		22e. ADDRESS 703 OAK Hill Ave. HAGERSTOWN MD												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11/30/83		23c. NAME OF CEMETERY OR CREMATORIAL Welsh Run Brethren			23d. LOCATION CITY OR TOWN Mercersburg, Franklin COUNTY Pa.							
24. FUNERAL DIRECTOR NAME J. M. Lininger		ADDRESS 17236 Mercersburg, Pa.			25a. DATE REC'D. BY REGISTRAR DEC 01 1983			25b. REGISTRAR'S SIGNATURE John J. Conigli						



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												31318																		
												REG. NO.																		
1 - STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)				FIRST		MIDDLE		LAST		2a. DATE OF DEATH				MONTH	DAY	YEAR	2b. HOUR										
			Robert Lee Timmons										November 9, 1983							6:45 p.m.										
3. SEX			4. RACE				5. DATE OF BIRTH				6. AGE (IN YEARS LAST BIRTHDAY)				IF UNDER 1 YEAR		IF UNDER 24 HRS													
Male			White				MONTH DAY YEAR October 4, 1895				88				MONTHS		DAYS		HOURS											
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH				10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY			
Pennsylvania			USA								WASHINGTON				Williamsport				Williamsport Nursing Home				Laborer				Textile			
13a. STATE			13b. COUNTY				13c. CITY OR TOWN				13d. INSIDE CITY LIMITS?				13e. STREET ADDRESS				14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME							
Maryland			Washington				Williamsport				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				16. S. Artizan St. 21795				FIRST				Ida				MIDDLE			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.				17. INFORMANT				18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				LAST															
no			213-18-8398				Harry B. Timmons/901 Chesnut St. Hag. MD 21740												Smith											
18. CAUSE OF DEATH (Enter only one cause per line for 18a, 18b, and 18c) PART I. DEATH WAS CAUSED BY												18c. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																		
IMMEDIATE CAUSE (a) 1850 Disseminated Intravascular Coagulation																														
DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic Prostate Cancer																														
DUE TO, OR AS A CONSEQUENCE OF (c) _____																														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																														
19a. MEDICAL CERTIFICATION			19b. DATE OF OPERATION				19c. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?				20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?															
											YES <input type="checkbox"/> NO <input type="checkbox"/>				YES <input type="checkbox"/> NO <input type="checkbox"/>															
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that (1) (this hospital) attended the deceased from 3/3/81 to 11/9/83, that (1) (we) last saw the deceased alive on 11/7/83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.																														
22b. SIGNATURE John R. Melnick			22c. DEGREE MD				22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22e. DATE SIGNED																			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS				16220 Frederick Rd Gaithersburg MD 20760																							
John R. Melnick, MD																														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE				23c. NAME OF CEMETERY OR CREMATORIAL				23d. LOCATION CITY OR TOWN				23e. COUNTY				23f. STATE											
Burial			Nov. 12, 1983				Welsh Run Church Cem.				Welsh Run				Franklin				Pennsylvania											
24. FUNERAL DIRECTOR NAME Major M. Osborne			ADDRESS Williamsport, MD 21795				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE																			
											NOV 14 1983				John J. Cawley															

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, *unless* retained by the hospital or attending physician.TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and completely filled in by the funeral director, *then* please remove carbon papers. *Page 1* and *Page 2* should be detached for use as the burial-trust permit. *Then* please remove carbon papers. *Page 1* and *Page 2* should be filed within 72 hours after death, with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner should be notified of the same.

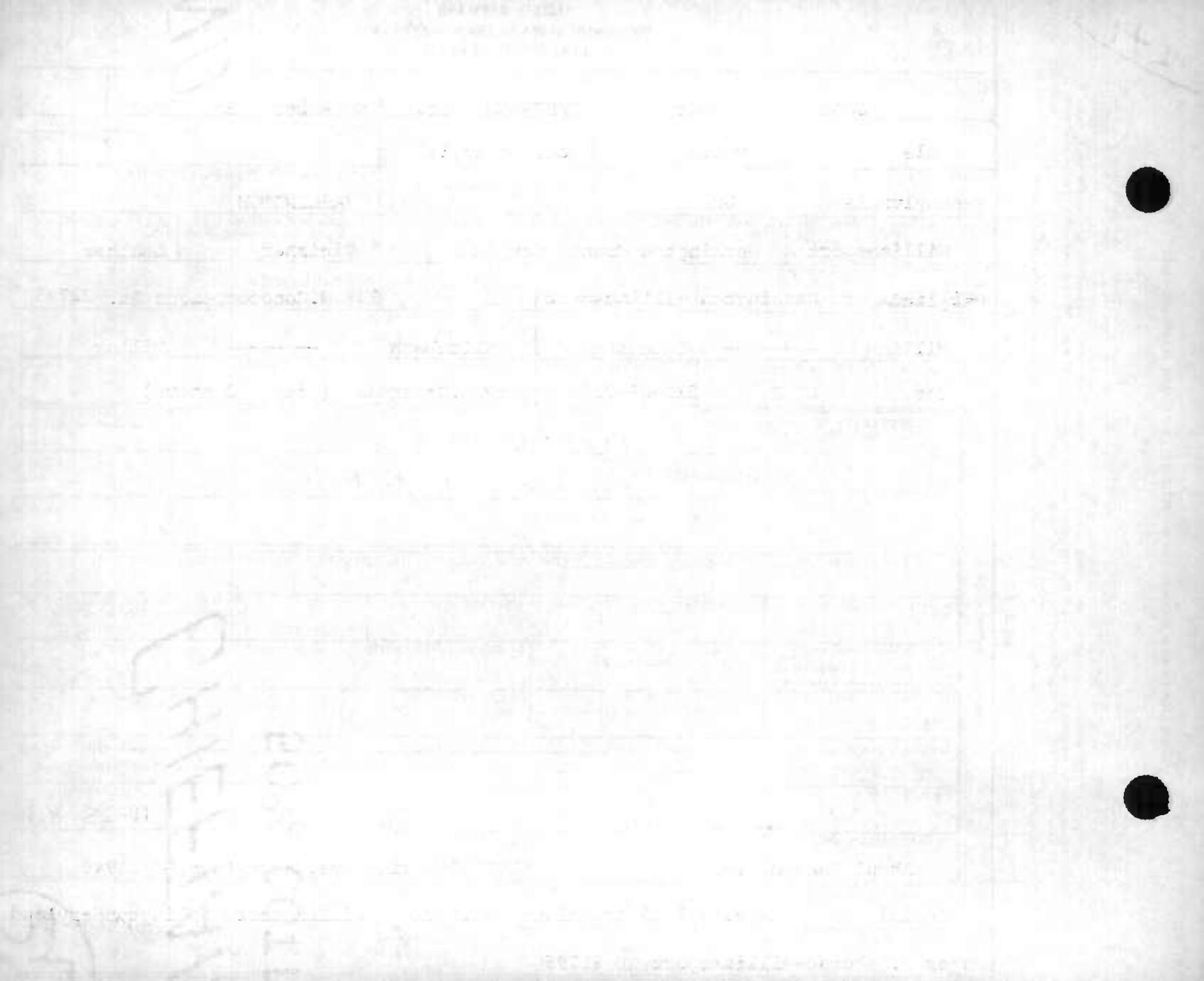
## MEDICAL CERTIFICATION

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

8 3  
3 1 3 1 9

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR		
John			Leroy	UPPERMAN, Sr.		November	25,	1983		M		
1. SEX		4. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)						
Male		White	MONTH October 15, 1898			IF UNDER 1 YEAR MONTHS    DAYS    HOURS    MIN.						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH WASHINGTON MD.						
Pennsylvania		USA										
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Williamsport		Washington County Hospital			Finisher			Leather				
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS					
Maryland		Washington	Williamsport				149 N. Conococheague St. 21795					
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			LAST				
William		-----	-----	Upperman	Elizabeth			Miller				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS				
Yes		WW I			215-09-7398			Mary L. Upperman (item 13 above)				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Garlic ash</i>											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
1541 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.												
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Carcinoma of rect</i>												
DUE TO, OR AS A CONSEQUENCE OF (c)												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <i>Abdul</i>		DEGREE <i>Abdul</i>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 11-25-83				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			1600 Oak Hill Ave. Hagerstown, MD 21740							
Abdul Waheed, M.D.												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL Greenlawn Mem. Park			23d. LOCATION CITY OR TOWN		COUNTY			
Burial		Nov. 28, 1983					Williamsport		Washington Maryland			
24. FUNERAL DIRECTOR NAME		ADDRESS			25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE NOV 28 1983							
Major M. Osborne-Williamsport, MD 21795												



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be forwarded for use on the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 18 is marked or Item 19 shows any injury, or other traumatic event, the medical examiner should be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND				DEPARTMENT OF HEALTH AND MENTAL HYGIENE				CERTIFICATE OF DEATH				REG. NO. 83 31320					
1 - STATE REGISTRAR																	
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
Christine						VALEK		11 13 83						10 05 AM			
3. SEX FEMALE		4. RACE White		5. DATE OF BIRTH MONTH 5 DAY 8 YEAR 1908				6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PA.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Washington		MONTHS		DAYS		HOURS		MIN.	
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) FACTORY WORKER		12b. KIND OF BUSINESS OR INDUSTRY 21740											
13a. STATE MARYLAND		13b. COUNTY WASHINGTON		13c. CITY OR TOWN HAGERSTOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS SUNRISE DR. RT. 6 Box 305									
14. FATHER'S NAME FIRST JOHN		MIDDLE		LAST Kodlick		15. MOTHER'S MAIDEN NAME CHRISTINA											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. No		16c. WAR OR DATES 166-03-1729		17. INFORMANT ELIZABETH FORREST		18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH HAGERSTOWN, SUNRISE DR. RT. 6. Box 305 MARYLAND									
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4360		DUE TO, OR AS A CONSEQUENCE OF (b) Stroke		DUE TO, OR AS A CONSEQUENCE OF (c)													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE							
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE D... D...		22c. DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED 11/13/83							
22e. PHYSICIAN'S NAME (THE PRINT)		22f. ADDRESS															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Nov. 17-1983		23c. NAME OF CEMETERY OR CREMATORIUM ST. JOHN SLOVAK LUTHERAN		23d. LOCATION CITY OR TOWN SUMMIT HILL		COUNTY CARBON		STATE PA.							
24. FUNERAL DIRECTOR NAME MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Maryland 21740						25. DATE REC'D. BY REGISTRAR NOV 18 1983		REGISTRAR'S SIGNATURE John J. Cawieh									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 2 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified of it.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												83	31321				
												REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR								
Thomas <i>Homes</i>			Andrew <i>Homes</i> Vantz			11/17/83			M								
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.							
Male		White		June 1, 1896			87 YRS.										
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			10. CITY OR TOWN OF DEATH							
Maryland		United States					Washington			Hagerstown							
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)												12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Washington County Hospital												Telegrapher			S.Pipeline		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> XX			13e. STREET ADDRESS		
13a. STATE Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Hancock			Rt. #2			21750							
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST														
James Peter Vantz			Bertha Catherine Oakes														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS								
No			220 09 9338			Mrs. Bette Crouse			Rt. 2 Hancock, Md. 21750								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Result of night dive acting as diver</i> (day)																	
4422 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>old age</i> (year)																	
DUE TO, OR AS A CONSEQUENCE OF (c)																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <i>Pulmonary Emphysema</i>																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM ETC.)			21f. LOCATION STREET			CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from <i>saw the deceased alive on 11/17/83</i> , to <i>19/20</i> , to <i>4/15</i> , 1983, that (I) (we) last viewed the body after death. (I) (we) did (did not) view the body after death.												22c. DATE SIGNED <i>11/17/83</i>					
22b. SIGNATURE <i>Edward J. Crouse</i>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>											
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE 11/17/1983			23c. NAME OF CEMETERY OR CREMATORIAL ST. PETERS CATHOLIC			23d. LOCATION CITY OR TOWN COUNTY STATE HANCOCK, WASHINGTON, MD. 21750								
24. FUNERAL DIRECTOR NAME <i>Kirkland J. Crouse</i>			ADDRESS <i>Hancock, MD.</i>			25a. DATE REC'D. BY REGISTRAR NOV 23 1983			25b. REGISTRAR'S SIGNATURE <i>John J. Crouse</i>								



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										83	31322			
										REG. NO.				
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR		
Patricia Louise Wacker						Nov. 3 1983						105 AM		
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS		
Female		White		Nov. 10-1936			46			YEARS	MONTHS	DAYS	HOURS	MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			10. CITY OR TOWN OF DEATH				
Ohio		U.S.A.					Washington			Hagerstown				
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY						
Hagerstown Washington County Hospital				Secretary				Hospital						
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS						
Maryland		Washington		Hagerstown		YES <input checked="" type="checkbox"/>		212 E. Irvin Avenue						
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		ADDRESS						
Walter		William		Cavanaugh		Rosa Elizabeth		Hag. Md.						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			Amy M. Stouffer 1028 Fairview Rd.					
No														
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiogenic Shock</u>										1 day				
4100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last														
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute myocardial Infarction</u>										1 week				
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerotic Heart Disease</u>										Years				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a). <u>Diabetes Mellitus.</u>														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
								YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE		
22a. I certify that (1) <u>the hospital</u> attended the deceased from <u>11-2</u> 19 <u>83</u> , to <u>11-3</u> 19 <u>83</u> , that in (my) <u>the</u> opinion death occurred on the date and hour and from the causes stated above, (1) <u>the</u> <u>did</u> <u>not</u> view the body after death.														
22b. SIGNATURE <u>Charles C. Spencer</u> MD										22c. DATE SIGNED 11-3-83				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>								
1198 Kunkel Ave														
23a. BURIAL, CREMATION, REMOVAL (SPECIAL)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			COUNTY	STATE	
Cremation			11-4-83			Smithburg Crematory			Smithburg			Wash.	Md.	
24. FUNERAL DIRECTOR NAME			305 N. Potomac St.			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE					
Gerald N. Minnich Hagerstown, Maryland						NOV 7 1983			<u>John J. Walsh</u>					
DHMH - 16 50M 4/82 (VRA 15, 4)														

W.L.A. 307 2.75000

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. It may be

## TO HOSPITAL OR ATTENDING PHYSICIAN: The

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. On 4 may be retained by the hospital or attending physician.

With the first 19 and the last 19 above, we have 38 numbers, or 9800 numbers in all.

STATE OF MARYLAND 8  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

31323

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
Robert Russell Walter						November	17	1983		1:30P M	
3. SEX	4. RACE	5. DATE OF BIRTH									
Male	White	Month Day Year April 16, 1939							IF UNDER 1 YEAR	IF UNDER 24 HRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8		MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Roaring Springs, Pa.		U. S. A.				WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Washington		MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION						12b. KIND OF BUSINESS OR (TYPE OF WORK FOR MOST OF WORK LIFE)	
Hagerstown		Washington County Hospital		U. S. GOV. Technical Information Specialist							
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13. STATE	14. COUNTY	15. CITY OR TOWN	13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS						
Maryland	Frederick	Myersville	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		10738 Grindstone Rd. 21773						
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
FIRST John	MIDDLE Arthur	LAST Walter	Ellen Louise Callaway								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS		
Yes			195-30-3497			Mrs. Betty M. Walter,			10738 Grindstone Rd.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			19. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
PART I. DEATH WAS CAUSED BY:  IMMEDIATE CAUSE (a) <u>Cardiogenic Shock</u>			20. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			21. DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute Myocardial Infarction</u>			22. Immediate		
4100									1 hour		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									years		
21c. DUE TO, OR AS A CONSEQUENCE OF (c) <u>Coronary artery disease</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a											
Recent Myocardial infarction											
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK	P.M. 19										
21d. INJURY OCCURRED	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)			21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>11-17 1983</u> , to <u>11-17 1983</u> , the (I) (we) last saw the deceased alive on <u>11-17 1983</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE	DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
W S Hood										11-17-83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS										
W S Hood	H.A.C. Md.										
23a. BURIAL, CREMATION, REMOVAL	23b. DATE	23c. NAME OF CEMETERY OR CREMATORIUM	23d. LOCATION CITY OR TOWN								
Burial	11-21-83	Boonsboro Cemetery	Boonsboro, Wash. Co., Md.								
24. FUNERAL DIRECTOR	25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE							
John H. Bast, Jr.	ADDRESS Boonsboro, Maryland 21713			NOV 22 1983							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8	3	3	1	3	2	4					
												REG. NO.											
1 - STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST John			MIDDLE Edgar			LAST WELTY			2a. DATE OF DEATH MONTH November YEAR 1983			2b. HOUR 5:45A M					
3. SEX Male			4. RACE White			5. DATE OF BIRTH MONTH May YEAR 1901			6. AGE (IN YEARS LAST BIRTHDAY) 82			IF UNDER 1 YEAR YRS.			IF UNDER 24 HRS MONTHS DAYS HOURS MIN								
7a. PLACE OF DEATH Beaver Creek, Md.			7b. CITIZEN OF WHAT COUNTRY? U. S. A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Washington			10. CITY OR TOWN OF DEATH Boonsboro			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 107 Lakin Ave.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Superintendent			12b. KIND OF BUSINESS OR INDUSTRY Cemetery		
13a. STATE Maryland			13b. COUNTY Washington			13c. CITY OR TOWN Boonsboro			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 107 Lakin Ave. 21713											
14. FATHER'S NAME FIRST Christopher			MIDDLE Newcomer			LAST Welty			15. MOTHER'S MAIDEN NAME Katie M. Jones														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? YES, NO OR UNKNOWN No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216-14-6168			17. INFORMANT Mrs. A. Irene Welty, Boonsboro, Md. 21713			ADDRESS 107 Lakin Ave.														
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			4100 Acute Coronary Occlusion									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Immediate											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerotic Heart Disease									Years											
			DUE TO, OR AS A CONSEQUENCE OF (c) Generalized Arteriosclerosis									Years											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a). Carcinoma of Prostate gland: Senile dementia																							
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)																	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE								
22a. I certify that (I) (his/hospital) attended the deceased from 9/7/78, 19, to Nov 2, 1983, that (I) (we) last saw the deceased alive on Oct 12, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																							
22b. SIGNATURE John A. Moran			DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 11/14/83														
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN A. MORAN M.D.			22e. ADDRESS 215 W Washington St Hagerstown, Md																				
23a. BURIAL, CREMATION, REMOVAL 15. BURIAL			23b. DATE 11- 4- 83			23c. NAME OF CEMETERY OR CREMATORIUM Boonsboro Cemetery			23d. LOCATION Boonsboro, Wash. Co., Md.														
24 FUNERAL DIRECTOR NAME John H. Bast, Jr.			ADDRESS Boonsboro, Maryland 21713			25a. DATE REC'D. BY REGISTRAR NOV 7 1983			25b. REGISTRAR'S SIGNATURE John J. Conroy														



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be left with the funeral director for 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												B 3 31325	
												REG. NO.	
1. FOR STATE REGISTRAR		2a. DATE OF DEATH MONTH DAY YEAR											
		CORA		ELIZABETH		LAST WHITTINGTON		NOVEMBER 12, 1983		Nov. 12 1983			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS			
FEMALE		WHITE		MONTH DAY YEAR		75		MONTHS DAYS		HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Maryland		U.S.A.		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Washington		Hagerstown		Washington County Hospital		Clerk	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS		12b. KIND OF BUSINESS OR INDUSTRY			
Maryland		Wash		Hagerstown		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1405 W. Church St. 21740		Hospital			
14. FATHER'S NAME		FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME									
		Harry		Shank		Clara				Shives			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS							
No		214-09-4708		John W. Whittington same as #13									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>5715</i> DO TO, OR AS A CONSEQUENCE OF (b) <i>Cirrhosis of liver</i> DO TO, OR AS A CONSEQUENCE OF (c) <i>6 months</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a). <i>Arterio-arteritic dementia - anemia - diabetes - cholesterol</i>													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>10/21</i> , 19 <i>83</i> , to <i>11/12</i> , 19 <i>83</i> , that (I) (we) last saw the deceased alive on <i>11/12</i> , 19 <i>83</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <i>E. Hoachlander MD</i>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>11/21/83</i>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>E. Hoachlander</i>		22e. ADDRESS <i>Hagerstown, Md.</i>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE <i>11/15/83</i>		23c. NAME OF CEMETERY OR CREMATORIAL Rest Haven Cemetery		23d. LOCATION CITY OR TOWN Hagerstown Wash.		COUNTY		STATE Md.			
24. FUNERAL DIRECTOR <i>Rest Haven Funeral Chapel, Inc.</i> 1601 Pennsylvania Ave. Hagerstown, Md.				25a. DATE REC'D. BY REGISTRAR <i>NOV 18 1983</i>		25b. REGISTRAR'S SIGNATURE <i>John G. Cawie</i>							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene, prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 (how, why, injury, or other traumatic event, the medical certificate should be mailed in on a separate sheet.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 31326			
1 - STATE REGISTRAR			1a. DECEASED NAME (TYPE OR PRINT)			1b. FIRST MIDDLE LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR
			Pauline W. Yount						11 19 83						2:00 P.M.
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Female			White			MONTH DAY YEAR			86			MONTHS	YEARS	HOURS	MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			10. CITY OR TOWN OF DEATH			
Westminster, MD.			USA						Boonsboro - Wash. Cty. MD.			Boonsboro			
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			13a. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13b. STREET ADDRESS			
FARHNEY - Keedy Mem. Home			Housewife						YES <input type="checkbox"/> NO <input type="checkbox"/>			649 Sussex Rd.			
14. STATE			15. COUNTY			13c. CITY OR TOWN			15. MOTHER'S MAIDEN NAME			16. ADDRESS			
MD.			Baltimore			Baltimore			Anna			WylRight			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 4149 IMMEDIATE CAUSE (a)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
NO			NOTE 212-09-2272			Lori Thompson LPN - FKH			Cardiac arrest						
Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last.			(b) 15 hours post - op												
DUE TO, OR AS A CONSEQUENCE OF (c)															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (II) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE						DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 11/19/83			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS												
ABDUL WAHED MD			1600 OAKHILL Av. Hyattsville, MD 20784												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			COUNTY	STATE		
CREMATION			11-21-83			SECURITY									
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE						
Booth Funeral Home			Westminster, MD			NOV 28 1983			James J. Cawley						

